Supreme Court, U.S
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No.

In The

Supreme Court of the United States

October Term, 1996

SCOTT D. LEVINE, M.D.,

Petitioner,

vs.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. f/k/a ORLANDO REGIONAL MEDICAL CENTER,

Respondents.

On Petition for Writ Of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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PETITION FOR WRIT OF CERTIORARI

JOHN C. BUTTERS
Attorney for Petitioner
P.O. Box 7129
Atlanta, GA 30357-0129
(404) 872-5693
(404) 876-3331 (Fax)
(*Counsel of Record*)

JAMES F. PONSOLDT
Of Counsel
Univ. of Ga.
School of Law
Athens, GA. 30602
(706) 542-5209

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QUESTIONS PRESENTED

1. Under Section One of The Sherman Act, does the legality of horizontal boycotts of competitors, which limit competition and consumer choice, depend upon proof of market definition and calculation of defendants' substantial market share?

2. Does a combination of competitors, through their professional association, that promotes and secures adherence to a fee schedule constitute a "kind of price-fixing" which is per se unlawful?

3. Should this Court summarily reverse or "gvr" a circuit court affirmance of summary judgment that does not consider or apply any of this Court's applicable but conflicting decisions, to preserve the appearance of consistency and a rule of law?

PARTIES TO THE PROCEEDING

Petitioner, Scott D. Levine, M.D., is a Board Certified internist who is a resident of Orlando, Florida. He was the Plaintiff in the lower court proceedings in this case and was Appellant before the United States Court of Appeals for the Eleventh Circuit.

Respondent Central Medical Affiliates, Inc. (CFMA) is an incorporated Florida professional association which is privately owned by its member physicians. The CFMA executive and administrative staff and offices are identical to those of codefendant Healthchoice, Inc. CFMA Board of Directors overlap with those of Healthchoice. CFMA and its member doctors do business in Orlando, Orange County, Florida. (Smith Dep. 7/21/93, pp 7-13; Neder Dep. p. 14). CFMA was a defendant in the lower court proceedings. CFMA was also an Appellee before the United States Court of Appeals for the Eleventh Circuit.

Respondent Orlando Regional Healthcare System, Inc. (ORHS) f/k/a Orlando Regional Medical Center is a privately

owned corporation under the laws of Florida. ORHS owns respondent Healthchoice, Inc., which is also a corporation under the laws of Florida and was created to organize and market a non-capitated fee-for-service preferred provider organization ("PPO") to provide healthcare to Orlando area employers and employees. ORHS also owns respondent Sand Lake Hospital and other hospitals in the Orlando Florida area. (Smith Dep. 7/21/93, pp. 7-13). These respondents were defendants in the lower court proceedings and were Appellees before the United States Court of Appeals for the Eleventh Circuit.

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OPINIONS BELOW

On January 23, 1996 the United States Court of Appeals for the Eleventh Circuit issued its opinion affirming the District Court's grant of summary judgment for the defendants. The opinion of the Eleventh Circuit (Appendix A) is reported as Levine v. CFMA et al, 72 F.3d 1538 (Jan 23, 1996) (No. 94-3145). The summary judgment opinion of the District Court appears in Appendix B.

STATEMENT OF JURISDICTION

The opinion of the United States Court of Appeals for the Eleventh Circuit affirming the judgment of the lower court was entered January 23, 1996. The timely petition for rehearing and suggestion for rehearing *en banc* were denied on March 18, 1996. Petitioner invokes jurisdiction of this Court pursuant to 28 U.S.C. §1254(1).

STATUTES INVOLVED

Sections One and Two of the Sherman Act, 15 U.S.C. §§1 and 2, provide in relevant part as follows:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . . (15 U.S.C. §1).
>
> "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed [to have violated this Act]. . . " (15 U.S.C.§2).

Rule 56, F.R.Civ.P., provides in relevant part as follows:

> ". . . The judgment shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, show that there is no genuine issue as to any material fact and that the moving party is entitled to a

judgment as a matter of law.. . "

STATEMENT OF THE CASE

Central Florida Medical Affiliates, CFMA, is a closed association of competing doctors which participates directly by contract in assuring adherence by its members to a fee schedule, termed a "master payor rate schedule," as a condition of membership in CFMA. (R4-110-Tab 36, §5.04). That rate schedule provides one factor in a two-factor product that equals the fee which CFMA members agree to charge the 68,000 CFMA patients. (R4-110-Tab 41, p. 100300; R3-86-Tab 2, ¶18).

CFMA members promulgated a so-called "Rule of Necessity" in 1985, by which physician participation in CFMA was closed to new applicants unless an internally determined "need" existed for certain physician specialities. (R4-110-Tab 28; Ex. 168, Doc. 00425 [Copy attached to Reply Brief of Appellant]).

CFMA acknowledges that a goal in maintaining closed membership is to protect members from competition for patients from non-member doctors, to assure each doctor in CFMA a sufficient number of patients to equal 15% - 20% of his respective practice, and to assure the defendant hospitals that they will receive sufficient patient referrals. (R4-110-Tab 42; R2-51-172-181). CFMA member doctors are required to do in hospital rather than outpatient procedures. (R4-110-Tab

37, Doc. # 100100; Cotrell Dep. p. 65; R4-110-Tab 1, para. 26). Member doctors also are prohibited from making patient referrals to non-member doctors. (R4-110-Tab 36, at 100023; Ex. 12).

In November, 1990, upon receiving active staff privileges at Sand Lake Hospital, Plaintiff hired an attorney to pursue an inquiry about admission to CFMA and Healthchoice (the affiliated preferred provider organization). (R4-110-Tab 1, ¶4). CFMA members provide medical services on a noncapitated fee-for-service basis to consumers whose employers have contracted with Healthchoice. (R4-110-Tab 36). Despite repeated requests, he was denied membership because of an alleged lack of "need" for internists located in his "quadrant" of Orlando, Florida, as designated and allocated by defendants. (R4-110-Tab 1; R4-110-Tabs 27, 28).

By written agreement each CFMA member-provider is required to refer patients only to other physicians or hospital members of the Healthchoice PPO. (R4-110-Tab 48). Each is also required to provide services to PPO patients if and only if "reimbursement for the services and procedures . . . is **based upon the current fee schedule**" collectively adhered to by CFMA physicians. (R4-110-Tab 38, at 100200).[1] By written

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Under any reading of the record, the CFMA combination of competing doctors is not an independent "messenger" model,

agreement Healthchoice assured the CFMA providers that it would seek to negotiate agreements with prospective payors guaranteeing fees to the doctors no less favorable than the doctors and CFMA jointly agreed to in the master payor rate schedule. (R4-110-Tab 36, at 100072, 76).

Finally, employees of the payors are financially penalized for using doctors outside CFMA. (R4-110-Tab 37; R4-100-26-27); and, provider doctors are forbidden from participating for six months in any other plan for a prospective Healthchoice payor who has declined to do business with Healthchoice. (R4-110-Tab 32, at 100023).

Less than two months after Plaintiff hired an attorney to pursue admission to CFMA, without notice, warning, or a hearing and without reviewing any patient charts or consulting with the head emergency room physician, on January 18, 1991, Plaintiff's medical staff and emergency room privileges were suspended at all ORHS hospitals at the initiative of a competing internist, Dr. Galceran. (R4-110-Tab 1, ¶4, 6, 10-

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as implied by the Court of Appeals, Levine at 1549 (and CFMA surely is not an insurance company), because provider members have combined directly to limit membership and to promote their association's role in assuring adherence to the previously determined rate schedule, as discussed below. CFMA staff members who are identical to the Healthchoice staff, establish the fee schedule.

12). Dr. Galceran was the Chief of Staff at Sand Lake Hospital and a member of the boards of directors of both CFMA and Healthchoice. (R4-95-12-13). The Board of Directors of CFMA and Healthchoice are interlocking. Healthchoice and Sand Lake Hospital are both privately owned by Orlando Regional Healthcare Systems (ORHS) (Smith Dep. 7/21/93, pp. 7-13)..

Soon after Plaintiff was denied membership in CFMA and his privileges were suspended, Dr. Galceran added an internist to his group who became a CFMA member automatically, despite the absence of "need." (R4-110-Tab 1, ¶26). Presumptively false and pretextual reasons were offered subsequently by defendants (based on the summary judgment record), as well as by Dr. Galceran, for Plaintiff's suspension, which decision defendants admit was "devastating" to Plaintiff (R4-102-22-23), and under CFMA guidelines prevented him from continuing to seek membership in CFMA. (R4-110-Tab 1, ¶ 6, 27, 28; R4-110-Tab 5; R4-110-Tab 17).

Plaintiff also was removed from ER call as an "administrative decision," with no review of his patient charts or his care of patients (R4-128-25). He was advised by a hospital committee chairman that his real problem was trying to be a "Jack of All Trades," that he should make referrals to CFMA specialists, because he was allegedly taking money from their pockets, and that he should do fewer out-patient and more in-hospital procedures. (R4-110-Tab 1, para. 11, 25; R4-

99-53-60).

The chairman of defendant's own credentials committee, Dr. Gilbert, subsequently testified by deposition that the loss of Plaintiff's privileges was not warranted. (Gilbert Dep. p. 85; R4-102-85). The only material considered by the defendant hospital executive committee in deciding to summarily suspend Plaintiff was a portion of a January 14, 1991 memorandum written by an associate executive director of Sand Lake Hospital, Susan Strifler, at the specific request of Dr. Galceran. (Deposition Strifler 9/29/93 pp 56-58; R4-97-56-58). No charts were reviewed. (Galceran Dep. p. 16; R4-96-16). Based on analyses by independent experts the memo contained false statements about Plaintiff's care of patients that were refutable by simple reference to the actual patient charts identified in the memo. (Depositions of Dr. Wells, Def. Ex 4, R4-110-Tab 5; and Dr. McMillan deposition Def. Ex. 2, R4-110-Tab 17; R4-110-Tab 1, ¶28)[2].

The following are only a few of the comments about the Strifler memo by Dr. Wells (see attachment to Wells' deposition in the record):

> "It appears Strifler did not adequately review the medical records as her comments are not accurate and are unsubstantiated..." (Wells affidavit ¶ C1; R4-110-Tab 4 p.1)
>
> "I can only believe that Strifler is either grossly incompetent or acting with malicious intent." (Wells affidavit ¶ C3d; R4-110-Tab 4 p.2)

Every independent expert Plaintiff has invited to review the Strifler memorandum that purportedly formed ORHS's basis for summary suspension of Plaintiff has concluded the ORHS conduct toward Plaintiff was baseless and pretextual[3]. (R4-110-Tab 1, ¶28). Defendants submitted no contradictory testimony. In short, on summary judgment the unrefuted evidence shows, inter alia, that Dr. Levine was granted full active staff privileges at the defendants' hospitals after a minimum period on provisional staff. He was subjected to 100% chart review and had a perfect quality assurance record. After developing a thriving medical practice, he sought admission to the doctors' privately owned professional organization, CFMA, was denied admission based upon the CFMA "Rule of Necessity" and determination that no "need" existed for more CFMA internists, and was promptly suspended from all staff privileges by those doctors and

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3 For example, Dr. LeFrock wrote:

"I find reading the charts, letters, and depositions that this whole affair is appalling and doctors should be spending more time taking care of patients and helping people instead of getting involved with underhanded cheap politics. One just gets the impression that the hospital, Dr. Brooks and a few other people have some personal vendetta against [Plaintiff]." (Attachment A to Plaintiff's Brief In Opposition To Motion For Attorney Fees; R6-156).

continually denied membership in CFMA. Dr. Galceran, with offices next to Dr Levine, then added a new internist to his practice group who was immediately admitted to CFMA. (R4-110-Tab 1, ¶26).

Defendants excluded Plaintiff from CFMA, and the CFMA doctors who are Plaintiff's competitors baselessly, summarily suspended his staff privileges because, in their words, Plaintiff was taking money from their pockets. (C. Brown dep. 2/8/94 p.55). Their closing CFMA and successful exclusion of Plaintiff enabled the CFMA doctors to continue to prevent price and service competition.

The trial court assumed much of the defendants' conduct to be illegal. Specifically, the District Court assumed "that the closed panel PPO that Healthchoice operates is an illegal restriction that violates the antitrust laws," (R6-147-14), but on summary judgment the District Court held that Plaintiff lacked standing to challenge his exclusion. (R6-147).

The Eleventh Circuit avoided the issue of standing, held that the per se rule for price fixing as established in United States v. Socony-Vacuum, 310 U.S. 150 (1940) and reaffirmed in Catalano, Inc. v. Target Sales, Inc., 100 S.Ct. 1925, 446 U.S. 643 (1980); Arizona v. Maricopa County Medical Society, 102 S.Ct. 2466 (1982) and Palmer v. BRG, 111 S.Ct. 401 (1990) did not apply (without discussing these decisions), Levine at 1548-49, and held that the per se rule for horizontal boycotts as established in Fashion Originators' Guild of

America v. FTC, 312 U.S. 457, 61 S.Ct. 703 (1941), and reaffirmed in Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959), U.S. General Motors, 86 S.Ct. 1321 (1966), and F.T.C. v. Superior Court Trial Lawyers Ass'n, 110 S.Ct. 768, 493 U.S. 411 (1990), did not apply (without discussing those decisions). Levine at 1549-53.

The Court finally held that Plaintiff could not satisfy the rule of reason because he allegedly did not define a relevant market for defendants and/or his practice was not destroyed, so there allegedly were no "actual detrimental effects." The Court apparently believed in its words, that plaintiff was seeking to "score a touchdown" of remuneration, and that his failure to do so did not demonstrate the existence of an antitrust violation. Levine at 1551.

REASONS FOR GRANTING THE WRIT

I.

CERTIORARI SHOULD BE GRANTED TO RESOLVE CONFLICT AND CONFUSION REGARDING THE PROPER LEGAL STANDARD TO DETERMINE THE LEGALITY OF HORIZONTAL BOYCOTTS OF COMPETITORS WHICH LIMIT COMPETITION AND CONSUMER CHOICE

The lower courts' refusal to submit the horizontal boycott claims in this case to a jury reflects a conflict with this

Court and other courts, as well as pervasive confusion regarding legal standards applicable to horizontal boycotts. Certiorari should be granted to resolve the continuing uncertainty regarding the proper legal standard to be applied in adjudicating the legality, under Section One of The Sherman Act, of horizontal boycotts of competitors, particularly in the context of health care markets.

As will be discussed below, this Court's decisions have allowed three conflicting legal standards for boycotts to evolve and uneasily co-exist: (1) the traditional rule of per se illegality, which disregards market definition and defendants' market share and provides that a horizontal agreement not to deal, or allow consumers to deal, with a competitor is unlawful, merely upon proof of the existence of such an agreement; (2) the traditional rule of reason analysis, as applied in vertical, non-price cases, which requires proof of the relevant market and calculation of defendants' substantial share of that market; and, (3) the middle ground, "quick-look" rule-of-reason approach, which allows condemnation of a horizontal agreement upon proof that it causes actual detrimental effects on consumers, such as preventing price or service competition, but without the need to define the relevant market.

Most recently the Department of Justice filed another civil action challenging a horizontal boycott, United States v. Scuba Retailers Association, Case No. 96-6112 (S.D.FL.

January 30, 1996) (alleging that a combination of retailers through a trade association to refuse to deal with manufacturers who supply competing mail order retailers is a horizontal group boycott and a naked restraint of trade in violation of Section 1 of the Sherman Act) . The government bases its action on the traditional per se theory of illegality as established in such cases as Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959)(manufacturers and distributors per se liable for conspiring with the retailers to boycott the retailer's competitor); U.S. General Motors, 86 S.Ct. 1321 (1966)(joint, collaborative action by dealers, trade associations, and General Motors to eliminate a class of competitors by terminating business dealings between them and a minority of Chevrolet dealers is a classic per se illegal conspiracy); and Associated Press v. United States, 326 U.S. 1 (1945) (a combination of newspapers which both restricted membership in a news-distribution joint venture and prohibited members from dealing with non-members, is per se unlawful.)

Under this approach, confirmed recently by Justice Scalia, horizontal boycotts of competitors are per se violations of Section One of the Sherman Act. In his dissenting opinion in Summit Health, Ltd v.Pinhas[4], 111 S.Ct. 1842 (1991),

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[4] While the decision in Pinhas was primarily focused on an interstate commerce issue, the statement by Justice Scalia is consistent with the earlier unanimous decision of this Court in

Justice Scalia (citing Robert Bork) explained:

> "...[G]roup boycotts are per se violations (not because they necessarily affect competition in the relevant market, but because they deprive at least some consumers of a preferred supplier, see R.Bork, The Antitrust Paradox 331-332 (1978))..." 111 S.Ct. 1851.

The Seventh and Third Circuits recently have condemned boycotts under the traditional per se rule when the motive for the boycott was to prevent price or service competition. See, Denny's Marina, Inc. v. Renfro Productions, Inc., 8 F. 3d 1217 (7th Cir. 1993)(combination of retailers and supplier to boycott a price cutting competitor is a per se illegal boycott and per se illegal price fixing in violation of Section 1 of the Sherman Act.); Alvord-Polk, Inc. v. F. Schumacher & Co., 37 F.3d 996, (3rd Cir. 1994) (boycott by a trade association of a discount wallpaper retailer was per se illegal).

The traditional rule of per se illegality has been thrown into question, however, by this court's decision in Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 105 S.Ct. 2613 (1985), when this Court, apparently in dicta, stated:

Superior Court Trial Lawyers, supra, one year earlier, and with Justice Scalia's frequently cited article "The Rule of Law As A Law of Rules," infra.

> "The mere allegation of a concerted refusal to deal does not suffice because not all concerted refusals to deal are predominantly anticompetitive. When the plaintiff challenges expulsion from a joint buying cooperative, some showing must be made that the cooperative possesses market power or unique access to a business element necessary for effective competition." 105 S.Ct. at 2621.

The language in Northwest Wholesale may have been affected by this Court's decision one year earlier applying such a "hybrid" per se rule (one requiring proof of defendant's market power) to vertical tying cases. See, Jefferson Parish Hospital Dist. v. Hyde, 466 U.S. 2, 12-15, 104 S.Ct. 1551, 1558-1560, 80 L.Ed.2d 2 (1984) (absent indication of market power, tying arrangement does not warrant per se invalidation).

In any event, the apparent abandonment in 1985 by this court in Northwest Wholesale of a straightforward per se rule for horizontal boycotts and substitution of a market power screen obviously took hold in the lower courts, and was the primary basis for the Eleventh Circuit's refusal to apply the per se rule to defendant's boycott activity in the present case. See, Levine p. 1550.

Northwest Wholesale was not this Court's last word regarding boycotts, however. First, in the following term, this court unanimously (a) reaffirmed that the per se rule may not apply to boycotts, at least when the targets are consumers

rather than competitors, but, (b) held that boycotts nevertheless would be condemned as unreasonable regardless of the absence of proof of market definition or market share (reversing the seventh circuit's contrary holding), when the boycott activity deprived consumers of desired services (dental X-rays). F.T.C. v. Indiana Federation of Dentists, 106 S.Ct. 2009, 2018 (1986).

To further confuse matters, in 1990 this Court resurrected the traditional per se rule against horizontal boycotts (reversing the court of appeals, which had insisted on proof of relevant market and market power) when used by professionals to increase price or prevent price competition. See, F.T.C. v. Superior Court Trial Lawyers Ass'n, 110 S.Ct. 768, 493 U.S. 411 (1990). Presumably, the decision in Superior Court was one basis for Justice Scalia's separate opinion in 1991 in Pinhas, supra. In the same term, this court reaffirmed the traditional rule of per se illegality (without need to define market or calculate market share) with respect to horizontal market allocation and price-fixing. See, Palmer v. BRG, 111 S.Ct. 401 (1990).

This Court's reaffirmation of the Sherman Act's traditional per se rule with respect to horizontal boycotts, price-fixing, and market allocation at the beginning of this decade served two broad goals: re-establishing "Rule of Law

as a Law of Rules" to serve basic democratic political values and limit the role of the judiciary as law-maker[5], and reaffirming the original purposes served by the per se rule in Sherman Act cases -- uniformity of decision, predictability of result, and efficiency of litigation[6]. Unfortunately, the lower courts frequently have not accepted this Court's leadership, as evidenced by the decision below in this case.

In the present case, as described above, plaintiff alleged and proved (sufficient to reach a jury) two kinds of horizontal boycott activity. Count one alleged that CFMA and its member doctors, by adopting and enforcing the CFMA "Rule of Necessity" restricting membership in CFMA and other rules limiting patient referrals and physician-consulting to CFMA members, erected a boycott of non-member doctors, including the Plaintiff, in order to protect member doctors from competition and to maintain their incomes; See, eg, Associated Press, supra.

Count three alleged that ORHS, its staff, and competing physicians, including Dr. Galceran, agreed to suspend Plaintiff's emergency room privileges, hospital admitting privileges, and privileges to do medical procedures,

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5 Scalia, "The Rule of Law As A Law Of Rules," 56 U. Chi. L. Rev. 1175, 1178 (1989).

6 Arizona v. Maricopa County Medical Society, 102 S.Ct. 2466 (1982)

thereby preventing patients and other doctors from dealing with him. This agreement, according to the uncontested record, was reached without review of patient charts, for "administrative" reasons, and based upon claims subsequently proven to be fraudulent, because plaintiff was making inadequate referrals to specialists, was doing too many outpatient (rather than in-hospital) procedures, was successfully taking business away from competing physicians, and was seeking to accomplish similar things with respect to the 68,000 Healthchoice patients.

The district court assumed the above conduct was unlawful but held that plaintiff, the target of both boycotts, had no "antitrust standing" (R6-147, pp. 3-7). The court of appeals did not address the obviously meritless "standing" contention, which defendants appeared to abandon at oral argument in the Eleventh Circuit.

Instead, the Eleventh Circuit ruled that, under Northwest Wholesale, supra, horizontal boycotts are not per se unlawful. The court further ruled that, under Indiana Federation, boycotts are not unreasonable unless they eliminated the plaintiff from the market, thereby misconstruing "actual detrimental effects" to mean effects on the plaintiff rather than effects on consumers. The Court failed to cite Superior Court, Associated Press, Klor's, General Motors, etc., and held that horizontal boycotts could be successfully challenged only if the plaintiff defined a relevant market and

calculated defendants' significant market share.

In other words, the court applied to horizontal boycotts a legal standard, involving a market power screen, which this Court specifically has rejected in Associated Press v. United States, 326 U.S. 1 (1945); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959; F.T.C v. Indiana Federation of Dentists, 106 S.Ct. 2009 (1986); and FTC v. Superior Court Trial Lawyers Assn., 493 U.S. 411 (1990).

The issue that must be resolved, and which has created substantial conflict and confusion,[7] Levine at 1552, is whether horizontal boycotts of competitors violate Section One of the Sherman Act only when the plaintiff has proven a relevant market, calculated defendant's market share, and demonstrated defendants' substantial market power. A "discretion-conferring" approach to judicial law-making, Scalia, "The Rule of Law As A Law Of Rules," 56 U. Chi. L. Rev. 1175, 1178 (1989), in antitrust cases has allowed the courts, including the Eleventh Circuit in this case, to use such an alleged legal standard, involving a "market power screen", transparently to prevent juries from resolving legitimate antitrust disputes in many, many cases, whether by manipulating market definition findings, see, eg., U.S. Anchor Mfg. v. Rule Industries, 7 F.3d

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[7] The Eleventh Circuit's effort to distinguish or dismiss Justice Scalia's views expressed in Pinhas is not a model of judicial clarity. Levine at 1554.

986 (11th Cir. 1993), or disregarding evidence of the exercise of market power. See, eg., Eastman Kodak Co. v. Image Technical Services, Inc. 112 S. Ct 2072 (1992).

This Court should clarify the confusion and reaffirm its model of a rule of law, and stare decisis, for horizontal boycott cases --that no market power screen is necessary-- as recognized in Superior Court and Indiana Federation of Dentists and by the Justice Department in its most recent boycott complaint in the Scuba Retailers' Association case, supra.

II.

CERTIORARI SHOULD BE GRANTED AND THE CASE REMANDED TO CONFIRM THE RULE THAT CONCERTED ADHERENCE TO A FEE SCHEDULE IS "A KIND OF PRICE FIXING" WHICH IS *PER SE* UNLAWFUL EVEN IF THE ENTIRE PRICE IS NOT FIXED

The Solicitor General has argued consistently to this Court on behalf of the United States, and this Court has held, that a combination among competitors to eliminate price competition and/or adhere to a fee schedule is per se illegal price-fixing, under Section One of the Sherman Act, even if entire fees are not literally fixed. This rule has been applied when competitors have combined directly or through a professional association. See, among others, Palmer (direct agreement to substitute a vertical relationship for a competitive

relationship and raise price, is per se illegal); Superior Court (agreement to seek increase in hourly fees is per se illegal); Arizona v. Maricopa County Medical Society, 102 S.Ct. 2466 (1982) (doctors' agreement through medical society, to adhere to fee schedule, per se illegal); Catalano (direct agreement to eliminate credit terms, a component of price, per se illegal); National Society of Professional Engineers v. United States, 98 S.Ct. 1355 (1978) (engineers' agreement, through professional society, to eliminate competitive bidding, per se illegal); Goldfarb v. Virginia State Bar, 421 U.S. 773, 95 S.Ct. 2004 (1975)(lawyers agreement, through bar association, to limit price competition in accordance with fee schedule, per se illegal); United States v. Socony-Vacuum, 310 U.S. 150 (1940) (direct agreement to reduce excess capacity and thereby stabilize price is per se illegal). The views of this court and the United States, as reflected by the decisions and pleadings in the above cases, have been consistent for fifty years.

Most lower courts have recognized and enforced this central antitrust rule. See, most recently, United States v. Alston, 974 F.2d 1206, at 1214 (9th Cir. 1992)("in a market consisting of individual service providers and individual consumers, concerted action by the suppliers even on matters not directly related to price is viewed with great suspicion. . .Needless to say adoption of suggested or (maximum) fee schedules will run afoul of Section One's per se rule as thinly-veiled attempts at price-fixing").

In the present case the Eleventh Circuit, whose decision in Palmer, supra, this court summarily reversed at the suggestion of the Solicitor General, has held that no reasonable jury could find that competing physicians and their professional association -- CFMA -- engaged in per se illegal price-fixing when they agreed to adhere to fees established by the staff of CFMA and Heathchoice in a so-called "Master-Payor Rate Schedule" :

> (1)"Healthchoice agrees that so long as this Agreement is in effect it shall: ... (c) use its **best efforts** to negotiate agreements with prospective payors ... seeking contracts with payors on terms no less favorable to Participating Physicians than as set forth in the Master Payor Rate Schedule, as may from time to time be amended..." (Exhibit 14, document 100070).
>
> "A Physician Provider shall accept a payment in full the payments as set forth in the Payor Rate Schedule."(Exhibit 16, #100150).

As a result of such agreement, CFMA member fees were stable, uniform and trended upward during a four year period. (R2-57).

The court ruled that such a combination was "a kind of price-fixing" but not per se unlawful because entire fees allegedly were not literally fixed:

> ". . . [T]he providers' actual fees are not set. The only figure that is set is the maximum allowable fee that they will be reimbursed by

> Healthchoice. . .
>
> This method of negotiating fees . . . is a kind of `price fixing,' but it is a kind that the antitrust laws do not prohibit." 72 F.3d at 1548.

Actual fees are a multiple of the Master Payor Rate Schedule and the CPT codes set by Medicare (Smith Dep 8/94). Levine at 1546. In view of the clear language of their contracts quoted above, it is not surprising that neither defendants nor the court could cite a single example of a physician member of CFMA charging any fee at variance with the rate schedule, and the evidence is that when CFMA members send bills, they expect payment as provided on the CFMA/Heathchoice schedule. (R4-110-Tab 40, ¶7.1; Galceran Dep. pp. 166-69).

CFMA is privately owned by the same hospital which owns Healthchoice, and their Boards of Directors overlap. CFMA appoints one-half of the members of the Board of Directors of Healthchoice (R4-110-Tab 32 at 100077) and included on the Board of Directors of Healthchoice are four doctors who are also members of the Board of Directors of CFMA, which requires adherence by CFMA members to the fee schedule. (Smith Dep. 7/21/93 pp. 11-13). Moreover, the executive staff and offices of Healthchoice are identical to those of CFMA. (Smith Dep. 8/94; Neder Dep. p 14). In other words, the same people who act for Heathchoice regarding implementation of the fee schedule also act directly for CFMA.

The "schedule", of course, merely establishes fees for

particular services: that schedule has been stable and trending upward during a four year period. Since CFMA members sell their services to Healthchoice patients on a "non-capitated" fee-for-service basis, they have no incentive to reduce overall services and overall medical fees, which likewise are increasing steadily, particularly as CFMA doctors make referrals to CFMA specialists or CFMA consultants and send healthchoice patients to ORHS rather than outpatient care, as they are required by CFMA and Healthchoice to do.

The Eleventh Circuit alternatively implied that this case involved a "messenger" model for physician fees, as when an independent insurance company demands that independent physicians charge in accordance with an insurance company's fee schedule -- thus contrasting this case with Maricopa. Levine at 1548-49. The suggestion that CFMA or Healthchoice is an independent insurance company, however, rather than a combination of physicians like the medical society in Maricopa, obviously conflicts with undisputed written contracts and other documents in this case. The direct relationship between ORHS, CFMA and Healthchoice at least creates a jury question regarding the "independence" of Healthchoice. Quite clearly, none of the defendant entities is independent from the competing providers. Rather, multiple contracts have united all defendants and their members.

In light of defendants' claims, through their attorneys, that they are simply doing what virtually all other preferred

provider organizations are doing in central Florida, the apparent conflict between this Court's and the United States' understanding of per se illegal price fixing, on one hand, and the Eleventh Circuit's refusal to allow even a jury to consider whether the "kind of price-fixing" involved in this case is in fact a combination to fix prices, should be resolved.

Certainly, in any event, the holding that "a kind of price-fixing" which is intended to and does prevent price competition is not subject to the rule of per se illegality cannot be squared with existing law and is appropriate for review by this Court, particularly in the context of health care markets where the containment of price increases through competitive models has become a paramount public policy issue.

III.
CERTIORARI SHOULD BE GRANTED TO CLARIFY WHEN THIS COURT SHOULD SUMMARILY REVERSE OR "GVR" A CIRCUIT COURT AFFIRMANCE OF SUMMARY JUDGMENT THAT DOES NOT CONSIDER OR APPLY ANY OF THIS COURT'S APPLICABLE BUT CONFLICTING DECISIONS

As discussed above, the opinion of the Eleventh Circuit is inconsistent with and fails to discuss significant precedent of this Court issued in the 1990's, including Palmer v. BRG of Georgia, Inc., 498 U.S. 46, 111 S.Ct. 401, (1990); F.T.C. v. Superior Court Trial Lawyers Ass'n, 110 S.Ct. 768, 493 U.S. 411 (1990); and, Eastman Kodak Co. v. Image Technical Services, Inc. 112 S. Ct 2072 (1992), even though Plaintiff

primarily relied on those decisions in the Court of Appeals.

The opinion is inconsistent with and fails to apply significant precedent of this Court rendered in the 1980's including Catalano, Inc. v. Target Sales, Inc., 100 S.Ct. 1925, 446 U.S. 643 (1980); Arizona v. Maricopa County Medical Society, 102 S.Ct. 2466 (1982); F.T.C v. Indiana Federation of Dentists, 106 S.Ct. 2009 (1986); and, NCAA v. Board of Regents of Univ. of Okla., 468 U.S.85 (1984).

The opinion is inconsistent with and fails to apply significant precedent of this Court rendered in the 1970's including Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); U.S. v. National Society of professional Engineers, 98 S.Ct. 1355, 435 U.S. 679 (1978), and United States v. United States Gypsum Co., 438 U.S. 422, 98 S.Ct. 2864 (1978). None of the above decisions has been reversed by Congress or this Court. All are "good law," supposedly binding on the lower courts.

The Eleventh Circuit opinion is also in conflict with and fails to reference significant precedent of other circuits, cited by petitioner, including Hammes v. AAMCO Transmissions, Inc., 33 F.3d 774 (7th Cir. 1994); Denny's Marina, Inc. v. Renfro Productions, Inc., 8 F. 3d 1217, (7th Cir. 1993); and, U.S. v. Alston, 974 F.2d 1206 (9th Cir. 1992)(adherence to fee schedules by dentists is per se illegal).

The words of Justice Scalia are relevant to this case:

"The trouble with the discretion-conferring

> approach to judicial law-making is that it does not satisfy this sense of justice very well. When a case is accorded a different disposition from and earlier one, it is important, if the system of justice is to be respected, not only that the later cases be different, but that it be seen to be so."

Scalia, "The Rule of Law As A Law Of Rules," 56 U. Chi. L. Rev. 1175, 1178 (1989).

Supreme Court Rule 10(a) in pertinent part states that a consideration for granting review is whether the opinion of the circuit court "has so far departed from the accepted and usual course of judicial proceedings . . . . as to call for an exercise of this Court's supervisory power." Recently in Lawrence v Charter, 116 S.Ct. 604 (1996), this Court articulated the views among the members of the Court regarding the appropriate use and practice of "GVR," when the lower court opinion did not consider governing precedent: When that is true, this Court indicated that granting certiorari, vacating the lower court decision, and remanding for reconsideration is light of governing precedent which had not been addressed was often the proper procedure.

Rule 10(a) and the majority opinion in Lawrence suggest that the present case is appropriate for use of "GVR," or for summary reversal, as was done in Palmer v. BRG, supra. "GVR" could be particularly efficient here where the circuit court opinion is inconsistent with numerous and longstanding Supreme Court decisions that the lower court opinion fails to

cite or address.

Recently this Court reversed and remanded to the Eleventh Circuit in Lonchar v. Thomas, 116 S.Ct. 1293 (April 1, 1996), because the Eleventh Circuit ignored established rules and precedent. In pertinent part this Court cautioned:

> "After all, . . . rules that guide lower courts reduce uncertainty, avoid unfair surprise, minimize disparate treatment of similar cases, and thereby help all litigants . . . " (116 S.Ct. at 1299)

> "In sum, we believe that this case should have been examined within the framework of the . . .Rules and settled precedents, not according to generalized equitable considerations *outside* that framework." (116 S.Ct. at 1303).

This language of Lonchar is very fitting in the case at bar where the Eleventh Circuit failed to discuss or cite longstanding Supreme Court antitrust precedent relied upon by Plaintiff in opposing summary judgment.

CONCLUSION

The Petition For Certiorari to review the judgment of the United States Court Of Appeal for the Eleventh Circuit should be granted.

Respectfully submitted,

JOHN C. BUTTERS
Attorney for Petitioner
P.O. Box 7129
Atlanta, GA 30357-0129
(404) 872-5693
(404) 876-3331 (Fax)

JAMES F. PONSOLDT
Of Counsel
Univ. of Ga.
School of Law
Athens, GA. 30602
(706) 542-5209

APPENDIX A - OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT FILED JANUARY 23, 1996

Levine v. Central Florida Medical Affiliates, Inc., 72 F.3d 1538, (11th Cir. 1996)

Scott D. LEVINE, M.D., Plaintiff-Appellant,

v.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; Healthchoice, Inc.; Sand Lake Hospital; Orlando Regional Healthcare System, Inc. f/k/a Orlando Regional Medical Center, Defendants-Appellees.

No. 94-3145.
United States Court of Appeals,
Eleventh Circuit.
Jan. 23, 1996.

Appeal from the United States District Court for the Middle District of Florida.

Before ANDERSON and CARNES, Circuit Judges, and OWENS (FN*), Senior District Judge.

CARNES, Circuit Judge:

Dr. Scott Levine, the plaintiff, appeals from the district court's grant of summary judgment in favor of the defendants on his state and federal antitrust claims. The four defendants are Healthchoice, Inc., a preferred provider organization ("PPO"); Central Florida Medical Affiliates, Inc.

("CFMA"), a physicians' advocacy group organized to supply physician providers to the Healthchoice PPO; Sand Lake Hospital; and Orlando Regional Healthcare System, Inc. ("ORHS"), the hospital's parent corporation. The incidents giving rise to the lawsuit are Dr. Levine's unsuccessful attempt to gain provider membership in Healthchoice and CFMA, and the temporary suspension of his staff privileges at Sand Lake Hospital. Because we conclude that there is no genuine issue of material fact about Dr. Levine's failing to establish any anticompetitive effect resulting from being denied membership in Healthchoice and CFMA or from his hospital suspension, and that the defendants are accordingly entitled to judgment as a matter of law, we affirm the district court's grant of summary judgment in their favor.

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I. BACKGROUND

Because the case has come to us on appeal of summary judgment, we construe the facts in the light most favorable to the nonmovant, in this case Dr. Levine. Forbus v. Sears Roebuck & Co., 30 F.3d 1402, 1403 n. 1 (11th Cir.1994), cert. denied, --- U.S. ----, 115 S.Ct. 906, 130 L.Ed.2d 788 (1995). The following is a

summary of the facts as viewed in the light most favorable to Dr. Levine.

Dr. Scott D. Levine is an internist. In 1989, a year after completing his residency in California, Dr. Levine moved to Orlando, Florida to begin private practice. Although Dr. Levine explored opportunities to join established medical practices as a salaried employee, (FN1) he ultimately decided to become a sole practitioner. He began his practice in the summer of 1989.

When Dr. Levine began his practice, he sought, and was granted, provisional staff privileges at the ORHS hospitals. (FN2) ORHS is a nonprofit organization that owns and operates five Orlando area hospitals: Orlando Regional Medical Center ("ORMC"); Arnold Palmer Hospital for Children and Women; Sand Lake Hospital; St. Cloud Hospital; and South Seminole Hospital (ORHS owns only half of it). Dr. Levine primarily exercised his staff privileges at Sand Lake Hospital because it is located across the street from his office. Around October of 1990, after Dr. Levine had successfully exercised his provisional staff privileges for more than a year, ORHS granted him full active staff

privileges. During 1990 and 1991, Dr. Levine also applied for, and was granted, staff privileges at several other Orlando area hospitals: the Florida Hospital system, which operates five hospitals; Glenbeigh Hospital; Charter of Orlando South Hospital; and Health Central.

When Dr. Levine acquired provisional staff privileges at Sand Lake Hospital, he agreed to have his name put on the emergency room ("ER") call list. Each day doctors of various specialties would be "on call" in the ER, which means that if a patient came to the ER and needed to see, for example, an internist, the hospital would contact the internist whose name appeared on the call list for that day. Dr. Levine found that being on the ER call list provided an effective means of building his new practice, and so during his early years in Orlando, he asked to be placed on the list as often as possible. Many of the patients Dr. Levine treated in the ER would continue to see him as their internist after leaving the hospital. In addition, these patients would often refer Dr. Levine new patients. Dr. Levine's strategy proved lucrative; in 1990, his first full year of private practice, Dr. Levine's pre-tax net earnings were

$553,176--more than twice the average earnings of Florida internists in private practice that year, according to studies conducted by the American Medical Association.

A. THE DENIAL OF HEALTHCHOICE PPO MEMBERSHIP TO DR. LEVINE

In addition to being on the ER call list, another method of building his practice that Dr. Levine explored was the possibility of becoming a physician provider of Healthchoice (FN3) and CFMA. (FN4) Healthchoice is a PPO, which is a form of managed health care coverage in which physicians agree to accept no more than a maximum allowable fee for services rendered to plan enrollees in exchange for a potentially higher volume of patients. CFMA is a physicians' advocacy group that was organized to supply the Healthchoice PPO with a panel of physician providers. Dr. Levine had heard that Healthchoice was one of the largest PPOs in the Orlando area, and he believed that Healthchoice patients accounted for approximately twenty percent of some member physicians' practices. Dr. Levine had also heard *1543 that Healthchoice physicians were, in his words, "very pleased with what

they're getting as reimbursement."

Dr. Levine sought physician provider membership with Healthchoice several times between 1989 and 1990, but Healthchoice denied his request for membership each time, explaining that it did not need any more internists in his geographical area. Believing (incorrectly) that in order to be a member of Healthchoice, one had to be a member of CFMA, Dr. Levine also inquired about membership in CFMA. However, Dr. Levine's telephone call to CFMA was answered by a Healthchoice employee, and Dr. Levine was again told that it did not need any more internists in his area.

During his first few years of practice, Dr. Levine pursued provider memberships in three other Orlando area PPOs--Health Advantage, Alta, and Aetna. He joined the Health Advantage PPO because it was part of the group health coverage he had purchased for himself and his office staff. When his own health coverage administrators switched to the Alta PPO, Dr. Levine then joined Alta as well. Dr. Levine also applied to become a physician provider of Aetna at the request of a patient, but Aetna denied his application for the same reason that Healthchoice had-

-Aetna already had enough internists in Dr. Levine's area. Although Dr. Levine received numerous solicitations from other area PPOs inviting him to become a physician provider, he turned down each of those offers.

In January of 1991, Dr. Levine's practice was so busy that he placed an advertisement in a medical journal to hire a physician as a salaried employee. However, because of events that transpired at Sand Lake Hospital that same month, Dr. Levine decided not to hire another physician for his practice.

B. THE SUSPENSION OF DR. LEVINE'S STAFF PRIVILEGES AT SAND LAKE HOSPITAL

In January of 1991, Cathy Canniff-Gilliam, the Executive Director of Sand Lake Hospital, removed Dr. Levine from the ER call list. A few days later, the executive committee of Sand Lake Hospital voted to suspend Dr. Levine's remaining staff privileges pending investigation of various patient care concerns. (FN5) The executive committee reported these concerns to the ORHS credentials committee, which then assembled an investigative committee to review the

incidents giving rise to those concerns. After interviewing Dr. Levine and reviewing his patients' charts, the investigative committee reported its findings to the credentials committee. The credentials committee reviewed the report and recommended to the Sand Lake Hospital executive committee that it place Dr. Levine on probation for six months and that it proctor his performance of certain procedures several times each. The executive committee decided to increase the probationary period to one year, but other than that, it adopted the credentials committee's recommendations. Dr. Levine appealed the executive committee's decision, and in June of 1991, ORHS appointed a hearing panel to review the executive committee's decision. The panel affirmed the executive committee's decision to impose probationary conditions upon Dr. Levine.

Subject to his new probationary status, Dr. Levine regained admitting privileges in May of 1991, and ER call privileges in the fall of 1991, although he chose to wait until mid-December to resume being on ER call. Dr. Levine still has not met the procedure proctoring requirements necessary to regain full staff privileges,

because he has chosen to admit his patients to Florida Hospital, which is the largest hospital system in Orlando, and as a result he has not performed the procedures that were to be proctored at Sand Lake Hospital.

During the time that his staff privileges were suspended at Sand Lake Hospital, (FN6) Dr. Levine maintained staff privileges at Glenbeigh *1544 Hospital, Charter Hospital, Health Central Hospital, and Florida Hospital (which includes five campuses). However, he has chosen not to exercise his staff privileges at Glenbeigh and Charter, purportedly due to the time he has spent pursuing this lawsuit.

The suspension of Dr. Levine's staff privileges began in the third week of January in 1991. Notwithstanding his suspension, in 1991 Dr. Levine earned $724,722, which is $171,546 (or thirty-one percent) more than he had earned the previous year when his Sand Lake Hospital staff privileges were not suspended.

II. PROCEDURAL HISTORY

In March of 1993 Dr. Levine filed a

complaint in the United States District Court for the Middle District of Florida against CFMA, Healthchoice, Sand Lake Hospital, and ORHS, alleging violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. Secs. 1 & 2 (1988), and violations of various state laws. (FN7) In Count 1 of his complaint, Dr. Levine claimed that CFMA and Healthchoice violated section 1 of the Sherman Act by maintaining a closed panel of physicians and by denying him physician provider membership. Dr. Levine claimed in Count 2 that all of the defendants conspired to, and did, monopolize the market for patients "whose employers have contracted with Healthchoice," in violation of section 2 of the Sherman Act. In Count 3 Dr. Levine claimed that ORHS and Sand Lake Hospital engaged in a concerted refusal to deal in violation of section 1 of the Sherman Act by suspending his staff privileges. (FN8) Dr. Levine sought monetary damages in excess of $100,000 and injunctive relief pursuant to sections 4 and 16 of the Clayton Act. (FN9)

In June of 1994, after extensive discovery, each defendant filed a motion for summary judgment as to the state and federal antitrust claims. The district

court granted the defendants' motions, and, declining to exercise its supplemental jurisdiction, the court dismissed the remaining state law claims without prejudice. Dr. Levine now appeals the district court's grant of summary judgment.

III. DISCUSSION

In granting the defendants' motions for summary judgment, the district court held that Dr. Levine lacked standing to prosecute his antitrust claims, and in the alternative that his claims lacked merit. As to Dr. Levine's section 1 and 2 claims against Healthchoice and CFMA for denying him membership, and his section 2 claim against ORHS and Sand Lake Hospital for their part in the alleged conspiracy to monopolize, the district court held he lacked standing because he was not an efficient enforcer of the antitrust laws, and in the alternative, that those claims were without merit because he had failed to prove the defendants' market power. As to Dr. Levine's section 1 claim against ORHS and Sand Lake Hospital for suspending his staff privileges, the district court held that he lacked standing because he had failed to establish that his

suspension resulted in any antitrust injury, and in the alternative, that the claims lacked merit because of Dr. Levine's failure to show any anticompetitive effect arising out of his suspension.

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[1] We need not decide whether Dr. Levine has met the requirements for standing as to any of his antitrust claims, because as to each one he has failed to establish any violation of the antitrust laws. (FN10) Because we believe Dr. Levine has failed to prove any anticompetitive effect resulting from the defendants' behavior, as is required under the Sherman Act, we follow the advice of Professors Areeda and Hovenkamp and decide this case on the merits rather than on standing:

> When a court concludes that no violation has occurred, it has no occasion to consider standing.... An increasing number of courts, unfortunately, deny standing when they really mean that no violation has occurred. In particular, the antitrust injury element of standing demands that the plaintiff's alleged

> injury result from the threat to competition that underlies the alleged violation. A court seeing no threat to competition in a rule-of-reason case may then deny that the plaintiff has suffered antitrust injury and dismiss the suit for lack of standing. Such a ruling would be erroneous, for the absence of any threat to competition means that no violation has occurred and that even suit by the government--which enjoys automatic standing--must be dismissed.

2 Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law p 360f, at 202-03 (rev. ed. 1995) (footnotes omitted). This approach is consistent with our precedents. We have ruled on the merits of an antitrust claim without ever deciding whether the plaintiff had antitrust standing. E.g., Aladdin Oil Co. v. Texaco, Inc., 603 F.2d 1107, 1109 n. 2 (5th Cir.1979) (assuming standing and affirming grant of summary judgment for defendants because plaintiff failed to establish antitrust violations); Hardwick v. Nu-Way Oil Co., 589 F.2d 806, 807 n. 3 (5th Cir.) (same), cert. denied, 444 U.S. 836, 100 S.Ct. 70, 62 L.Ed.2d 46 (1979); see also Todorov v. DCH Healthcare Auth., 921 F.2d 1438, 1446-47

(11th Cir.1991) (reaching the merits of an antitrust claim even though the plaintiff lacked standing to bring the claim).

[2] We review a district court's grant of summary judgment de novo. Flores v. Carnival Cruise Lines, 47 F.3d 1120, 1122 (11th Cir.1995). Viewing the facts in the light most favorable to the nonmovant, we must determine whether there exists a genuine issue of material fact or whether the movant is entitled to judgment as a matter of law. Tisdale v. United States, 62 F.3d 1367, 1370 (11th Cir.1995).

A. THE SECTION 1 CLAIMS

[3] Section 1 of the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C.A. Sec. 1 (West 1973). A section 1 plaintiff must prove an agreement between two or more persons to restrain trade, because unilateral conduct is not illegal under section 1. See, e.g., Fisher v. City of Berkeley, Cal., 475 U.S. 260, 266, 106 S.Ct. 1045, 1049, 89 L.Ed.2d 206 (1986)

("Even where a single firm's restraints directly affect prices and have the same economic effect as concerted action might have, there can be no liability under Sec. 1 in the absence of agreement."); Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 761, 104 S.Ct. 1464, 1469, 79 L.Ed.2d 775 (1984); Todorov, 921 F.2d at 1455. Thus, the first element of a section 1 claim is proof of an agreement to restrain trade.

[4][5][6] However, not every agreement that restrains competition will violate the Sherman Act. The Supreme Court long ago determined that section 1 prohibits only those agreements that unreasonably restrain competition, Standard Oil Co. v. United States, 221 U.S. 1, 58-64, 31 S.Ct. 502, 515-17, 55 L.Ed. 619 (1911), thus, the unreasonableness of the agreement is the second element of a section 1 claim. In identifying which agreements unreasonably restrain competition, the Supreme Court has held that certain kinds of agreements are unreasonable per se, such as agreements among direct competitors to fix prices or to restrict output. E.g., United *1546 States v. Socony-Vacuum Oil Co., 310 U.S. 150, 224-26 n. 59, 60 S.Ct. 811, 845-46 n. 59, 84

L.Ed. 1129 (1940). The only inquiry in such cases is whether there was an agreement to do so, because the unreasonableness of the restraint is presumed. See, e.g., Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 344-45, 102 S.Ct. 2466, 2473-74, 73 L.Ed.2d 48 (1982); United States v. Trenton Potteries Co., 273 U.S. 392, 397-98, 47 S.Ct. 377, 379, 71 L.Ed. 700 (1927). Agreements that do not fit within an established per se category are analyzed under the "rule of reason," i.e., courts will engage in a comprehensive analysis of the agreement's purpose and effect to determine whether it unreasonably restrains competition. E.g., Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 24-25, 99 S.Ct. 1551, 1565, 60 L.Ed.2d 1 (1979).

1. The Section 1 Claim Against Healthchoice and CFMA

A more detailed description of how the Healthchoice PPO and CFMA operate is necessary to a discussion of the merits of Dr. Levine's claims against those two defendants.

a) How Healthchoice and CFMA Operate

Healthchoice markets to healthcare payors a panel of select healthcare providers--which includes physicians, hospitals, pharmacies, and durable medical equipment companies. The payors consist of employers, insurance companies, third party administrators, or governmental agencies. Healthchoice maintains a limited panel of providers who have agreed to accept no more than a maximum allowable fee for services rendered or products furnished to Healthchoice enrollees. These maximum fees may or may not be lower than the provider's ordinary charges. In addition, the providers agree to be subject to Healthchoice's utilization review and quality control program. Providers are willing to accept these terms because Healthchoice membership may increase their number of patients.

Healthchoice individually negotiates with each payor to arrive at a schedule of fees that the payor is willing to pay for various medical products and services. Healthchoice presents each prospective payor with its schedule of fees, and the payor is then free to negotiate with Healthchoice for lower fees. Several steps are involved in computing Healthchoice's schedule of fees. Every

medical product and service is identified according to a standardized "Current Procedural Terminology" code ("CPT code"). Healthchoice assigns to each CPT code, of which there are approximately 9,000, a unit value that it adapts from information provided by Medicare. The unit value is a reflection of the approximate cost of resources required for each procedure or product. Healthchoice then assigns a monetary conversion factor to each major medical specialty, e.g., medicine has one conversion factor, and radiology has another; these conversion factors are collectively called the "Master Payor Rate Schedule." The Healthchoice fee schedule is computed by multiplying the conversion factors on the Master Payor Rate Schedule by the unit values assigned to the CPT codes. The resulting schedule of fees, once accepted by the payor, are the maximum that the payor will reimburse a provider for each product or service. Thus, when a payor receives a bill from a provider, it pays the provider the lesser of either the actual charges submitted by the provider, or the maximum allowable fee as reflected in the Healthchoice fee schedule.

Healthchoice does not consult its

various providers when it compiles the unit values or the conversion factors. The Healthchoice board of directors has eight members, four of whom are CFMA physicians, but when that board approves the Master Payor Rate Schedule, those four physician board members are not allowed to participate. In its contract with a provider, Healthchoice includes the conversion factors, but it does not include the unit values. Thus, the provider does not know the exact fees that Healthchoice has negotiated with the payors. Instead, the contract with each provider includes only an example of how a fee would be calculated for one of the more commonly used CPT codes. Should a provider request more information about the fee schedule, Healthchoice will give the provider a few more illustrations. The provider is always #1547 allowed to "opt out" of a contract with a given payor if it finds the fee reimbursement unacceptable. (FN11)

A Healthchoice enrollee is free to use non-Healthchoice providers; however, the enrollee's payor may require the enrollee to pay a higher deductible, and may require the enrollee to pay for any provider charges over the payor's maximum

allowable reimbursement. The payors individually design the terms of these benefit packages--Healthchoice itself does not create financial disincentives for any enrollees who choose to use non-Healthchoice providers.

The main source of Healthchoice's physician providers is CFMA, which was organized to supply Healthchoice with a panel of physician providers. Four members of CFMA sit on the board of directors of Healthchoice. However, Healthchoice does not contract only with CFMA for physician providers; many of Healthchoice's physician providers are not members of CFMA. Healthchoice providers, whether or not members of CFMA, are allowed to participate in other PPOs, and most of them do participate in several different PPOs.

For a short period of time after Healthchoice began doing business, it accepted applications from any provider who wanted to apply. Thereafter, Healthchoice decided to limit the size of its panel, and so it adopted a need-based system for determining how many providers of various specialties to include on its panel. Healthchoice stopped accepting

applications from physicians in those specialties that were already adequately represented on the provider panel. This need-based system is administered by the Healthchoice staff; providers do not participate in determining how many providers are needed on the Healthchoice panel. The Healthchoice staff also handles all inquiries regarding provider panel membership opportunities, without discussing those inquiries with the board of directors.

Healthchoice considers numerous factors in deciding how many providers to have on its panel, including: (1) the number of enrollees in the plan; (2) the geographic location of enrollees and providers; (3) the physicians' specialties; (4) the administrative costs of managing providers; (5) the special needs of particular payors; and (6) the availability of access to existing members, i.e., how long a patient has to wait to get an appointment with a Healthchoice provider. Although Healthchoice's general policy is to add new providers only when the need arises, if an existing Healthchoice provider adds a physician to his group practice, that new physician is automatically eligible to

become a Healthchoice provider, subject to the new physician's meeting Healthchoice's credentialling standards. The purpose of the exception to the need-based system is to avoid the administrative difficulties associated with cross-coverage: because physicians in a group practice cover for one another when they take time off, Healthchoice determined that it would be more cost effective to exercise its utilization review and quality control over the whole practice group.

Healthchoice asks its providers to refer Healthchoice patients to other Healthchoice providers whenever feasible. If a provider continually refers Healthchoice patients to non-Healthchoice physicians without justification, Healthchoice may remove that provider from the panel. This provision helps assure that Healthchoice and the payors can manage the costs of healthcare. Because non-Healthchoice physicians are not subject to Healthchoice's utilization review system, the payors have no effective means of determining whether the care rendered by a non-Healthchoice physician is necessary or cost efficient.

[7] As of the date that discovery was

complete in this case, Healthchoice had approximately 68,000 covered lives in the Orlando area, which had a population of more than 1.1 million. (FN12) There were approximately *1548 865 Healthchoice physician providers among the more than 2,200 licensed physicians in the Orlando area. At that time, Healthchoice competed with thirty-seven other PPOs, eleven Health Maintenance Organizations ("HMOs"), and numerous traditional insurance coverage companies.

b) The Merits of the Section 1 Claim Against Healthchoice and CFMA

Dr. Levine alleges that Healthchoice, CFMA, and their member physicians have conspired to unreasonably restrain competition in violation of section 1 of the Sherman Act by maintaining a closed panel of provider physicians, by creating a financial disincentive for enrollees who want to use non-Healthchoice physicians, and by prohibiting Healthchoice physicians from referring enrollees to non-Healthchoice physicians. Dr. Levine argues that these features restrict the availability of physician services to Healthchoice enrollees, lead to price stabilization in the market for physician

services, and render excluded physicians incapable of competing for Healthchoice patients. Dr. Levine primarily characterizes the activities of the defendants as a group boycott, or a concerted refusal to deal, however, he occasionally refers to the defendants' activities as illegal price fixing. We will first discuss his contention that the defendants have illegally fixed prices, and then his contention that they have engaged in a concerted refusal to deal.

i) The Alleged Agreement to Fix Prices

[8] Although Dr. Levine did not specifically argue to this Court that the defendants illegally fixed prices, i.e., provider fees, there are portions of his brief where he appears to assume the existence of such an agreement. That assumption is contrary to the uncontroverted evidence in the record, which establishes that there was no agreement between Healthchoice, CFMA, and their member physicians to fix provider fees. Healthchoice negotiates the provider reimbursement schedule directly with payors, not with providers. Healthchoice does not consult any physician providers when it compiles the

CPT code unit values or the Master Payor Rate Schedule, and physician members of the Healthchoice board of directors are excluded from the reimbursement schedule proposal and approval process. Providers must either accept not more than the maximum reimbursement negotiated by Healthchoice with the payors and not charge the patient for any difference between their fee and the reimbursement, or else opt out of the plan. The result is that the providers' actual fees are not set. The only figure that is set is the maximum allowable fee that they will be reimbursed by Healthchoice. Nothing prevents the physician from dropping his fees even further in order to compete should he choose to do so.

This method of negotiating fees, in which the payors decide the maximum amount they are willing to reimburse providers for medical services and providers decide whether they are willing to accept that limitation on the reimbursement they receive, is a kind of "price fixing," but it is a kind that the antitrust laws do not prohibit. See, e.g., Kartell v. Blue Shield, 749 F.2d 922, 923-26 (1st Cir.1984) (Breyer, J.), cert. denied, 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322

(1985); Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 745 F.2d 248, 256-57 (3d Cir.1984), cert. denied, 471 U.S. 1016, 105 S.Ct. 2021, 85 L.Ed.2d 303 (1985); Medical Arts Pharmacy v. Blue Cross & Blue Shield, 675 F.2d 502, 504-06 (2d Cir.1982); see also 8 Phillip E. Areeda, Antitrust Law p 1622b (1989). Because there is no genuine issue of material fact regarding the existence of an agreement among Healthchoice, CFMA, or its member doctors to fix provider fees, and because the defendants are entitled to judgment as a matter of law, Dr. Levine's section 1 claim against these defendants, to the extent that it alleges illegal price fixing, fails.

Our decision that Healthchoice's method of negotiating with payors the fees it pays providers does not violate the Sherman Act as a matter of law is supported by the Department of Justice and the Federal Trade Commission's recently issued "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust" ("DOJ Enforcement Policy" or "the policy"), available in WESTLAW, 1994 WL 642477 *1549 (F.T.C.). The DOJ Enforcement Policy separates those multiprovider

networks wherein competitors agree with one another regarding prices or market allocation, from those networks wherein such decisions are handled unilaterally by each competitor or through a third party "messenger." The policy defines the "messenger model" as involving "an agent or third party conveying to purchasers information obtained individually from providers in the network about prices the network participants are willing to accept, and conveying to providers any contract offers made by purchasers." Id. at *38 (footnote omitted). The latter will "rarely present substantial antitrust concerns." Id. The policy states that "[t]he critical antitrust issue is whether the arrangement creates or facilitates agreements that restrict price or other significant terms of competition among the provider members of the network." Id. at *39. In this case, there is no evidence that the Healthchoice method of negotiating maximum fee reimbursement facilitates any agreements among its provider panel members to restrict price or any other forms of competition. (FN13)

ii) The Alleged Concerted Refusal to Deal

Although there is no genuine issue of

material fact regarding the existence of an agreement to fix prices. Dr. Levine submitted evidence sufficient to establish a genuine issue of material fact regarding the existence of a concerted refusal to deal, i.e., agreements among Healthchoice, CFMA, and their member providers to restrict the size of the provider panel, and to discourage providers from referring Healthchoice enrollees to non-Healthchoice physicians. Thus, for purposes of defeating summary judgment against him, Dr. Levine has established the first element of his section 1 claim to the extent that it alleges a concerted refusal to deal. The question remains whether the agreements in question are an unreasonable restraint on competition as required to establish the second element of a section 1 claim.

[9][10] Before we can determine whether the Healthchoice and CFMA agreements are an unreasonable restraint on competition, we must first decide whether to analyze them under the per se rule or the rule of reason. "[A] restraint may be adjudged unreasonable either because it fits within a class of restraints that has been held to be 'per se' unreasonable, or because it violates what has come to be known as the

'Rule of Reason.' " F.T.C. v. Indiana Fed'n of Dentists, 476 U.S. 447, 457-58, 106 S.Ct. 2009, 2017, 90 L.Ed.2d 445 (1986). "The presumption in cases brought under section 1 of the Sherman Act is that the rule-of-reason standard applies." Seagood Trading Corp. v. Jerrico, Inc., 924 F.2d 1555, 1567 (11th Cir.1991). We apply the per se rule "only when history and analysis have shown that in sufficiently similar circumstances the rule of reason unequivocally results in a finding of liability," Consultants & Designers, Inc. v. Butler Serv. Group, Inc., 720 F.2d 1553, 1562 (11th Cir.1983), i.e., when the conduct involved "always or almost always tend[s] to restrict competition and decrease output." Broadcast Music, Inc., 441 U.S. at 19-20, 99 S.Ct. at 1562. We will not apply the per se rule "to restraints of trade that are of ambiguous effect." Consultants & Designers, 720 F.2d at 1562; see also Indiana Fed'n of Dentists, 476 U.S. at 458-59, 106 S.Ct. at 2018 (declining "to extend per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious"); National Soc'y of Professional Eng'rs v. United *1550 States, 435 U.S.

679, 692, 98 S.Ct. 1355, 1365, 55 L.Ed.2d 637 (1978).

[11] Dr. Levine characterizes the agreement to limit the size of the provider panel and to discourage provider members from referring Healthchoice patients to non-Healthchoice physicians as a group boycott and urges this Court to apply the per se rule. But this Court has stated that "[t]he attachment of the group boycott label does not necessarily require as a consequence an application of the per se approach." Consultants & Designers, 720 F.2d at 1561 (citation and quotation marks omitted) (alteration in original). "The labeling of a restraint as a group boycott does not eliminate the necessity of determining whether it is a 'naked restraint of trade with no purpose except stifling competition.' " Id. (quoting White Motor Co. v. United States, 372 U.S. 253, 263, 83 S.Ct. 696, 702, 9 L.Ed.2d 738 (1963)). In F.T.C. v. Indiana Federation of Dentists, the Supreme Court described the kind of the boycotts subject to the per se rule:

> Although this Court has in the past stated that group boycotts are unlawful per se, we decline to resolve this case

> by forcing the [defendant's] policy into the "boycott" pigeonhole and invoking the per se rule. As we observed last Term in Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 105 S.Ct. 2613, 86 L.Ed.2d 202 (1985), the category of restraints classed as group boycotts is not to be expanded indiscriminately, and the per se approach has generally been limited to cases in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor ....

476 U.S. at 458, 106 S.Ct. at 2018 (emphasis added) (citation omitted).

Dr. Levine bases his concerted refusal to deal claim on Healthchoice's denial of his repeated attempts to apply for membership, and its rule discouraging panel members from referring patients to physicians outside the network. This case does not involve the kind of group boycott that warrants application of the per se rule, i.e., it is not a "naked restraint of trade with no purpose except stifling competition." Consultants & Designers, 720 F.2d at 1562. We will analyze the

facts of this case under the rule of reason, instead of the per se approach, for two reasons. First, we are persuaded that because Dr. Levine has not proven that Healthchoice and CFMA have market power, (FN14) the Supreme Court's decision in Indiana Federation of Dentists, a pertinent part of which is quoted above, precludes us from applying the per se rule to these facts.

Second, the DOJ Enforcement Policy supports our decision to apply the rule of reason instead of the per se rule. The policy states that "[b]ecause multiprovider networks are relatively new to the health care industry, the Agencies do not yet have sufficient experience evaluating them to issue a formal statement of antitrust enforcement policy." DOJ Enforcement Policy, available in, WESTLAW, 1994 WL 642477, at *37 (F.T.C.). As previously noted, this Court is loath to condemn a practice as per se violative of the antitrust laws unless experience has shown that it always leads to anticompetitive effects in the market, Consultants & Designers, 720 F.2d at 1562, and the DOJ policy statement evidences that such experience is lacking with respect to multiprovider networks.

The DOJ Enforcement Policy also provides guidance on how to analyze the multiprovider network practice of excluding particular providers:

> Most multiprovider networks will contract with some, but not all, providers in an area. Such selective contracting may be a method through which networks limit their provider panels in an effort to achieve quality and cost containment goals and enhance their ability to compete against other networks. One reason often advanced for selective contracting is to ensure that the network can direct a sufficient patient volume to its providers to justify price concessions or adherence to strict quality controls by the providers. Where a geographic market can support several multiprovider networks, there are not likely to be significant competitive *1551 problems associated with the exclusion of particular providers by particular networks.

A rule of reason analysis usually is applied in judging the legality of excluding providers from a multiprovider network. The focus of the analysis is

> not on whether a particular provider has been harmed by the exclusion, but rather whether the exclusion reduces competition among providers in the market and thereby harms consumers. Therefore, exclusion may present competitive concerns if providers are unable to compete effectively without access to the network, and competition is thereby harmed. The Agencies also recognize, however, that there may be procompetitive reasons associated with the exclusion, such as the provider's competence or ability and willingness to meet the network's cost-containment goals. In addition, in certain circumstances network membership restrictions may be procompetitive by giving non-member providers the incentive to form other networks in order to compete more effectively with the network.

DOJ Enforcement Policy at *42. We find no fault with that analysis, and consistent with it we conclude that the rule of reason applies to Dr. Levine's section 1 claim against Healthchoice and CFMA.

[12][13] Under the rule of reason, the

"test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." Chicago Bd. of Trade v. United States, 246 U.S. 231, 238, 38 S.Ct. 242, 244, 62 L.Ed. 683 (1918). Rule of reason analysis requires the plaintiff to prove (1) an anticompetitive effect of the defendant's conduct on the relevant market, and (2) that the conduct has no procompetitive benefit or justification. E.g., Consultants & Designers, 720 F.2d at 1562.

[14] In order to prove an anticompetitive effect on the market, the plaintiff may either prove that the defendants' behavior had an "actual detrimental effect" on competition, or that the behavior had "the potential for genuine adverse effects on competition." In order to prove the latter, the plaintiff must define the relevant market and establish that the defendants possessed power in that market. Indiana Fed'n of Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2019; Capital Imaging Assoc., P.C. v. Mohawk Valley Medical Assoc., Inc., 996 F.2d 537, 546 (2d Cir.) ("[W]here the plaintiff is unable to

demonstrate ... actual effects, it must at least establish that defendants possess the requisite market power so that their arrangement has the potential for genuine adverse effects on competition." (citation and quotation marks omitted)), cert. denied, --- U.S. ----, 114 S.Ct. 388, 126 L.Ed.2d 337 (1993). We analyze the concerted refusal to deal in this case first for actual detrimental effect on competition, and then for potential adverse effect.

[15][16] Dr. Levine contends that he has shown actual detrimental effects, i.e., that the defendants intended to, and did, restrict competition. But Dr. Levine has failed to support with any evidence his conclusory assertion that the defendants' behavior actually had the effect of restricting competition. Indeed, the evidence in the record suggests the contrary. Although Healthchoice and CFMA denied him membership, Dr. Levine had no trouble establishing a booming practice. Dr. Levine opened a solo practice in 1989 with one patient, and in a little more than a year his practice was so busy that he began advertising to hire another physician. Dr. Levine acknowledges his extraordinary success--which earned him

more than half a million dollars in his first full year of practice and nearly three quarters of a million dollars his second year--but he argues that had he been allowed to join Healthchoice, he would have been able to "score a touchdown." The antitrust laws are intended to protect competition, not competitors, see Brown Shoe Co. v. United States, 370 U.S. 294, 344, 82 S.Ct. 1502, 1534, 8 L.Ed.2d 510 (1962); Todorov, 921 F.2d at 1450, and we will not depart from that purpose in order to improve Dr. Levine's income standings in the physician league or help him win the Super Bowl of remuneration.

Dr. Levine also contends that he has shown actual detrimental effects on competition by showing that Healthchoice's closed *1552 panel resulted in fees rising and stabilizing, but there is no evidence of that in the record. Dr. Levine relies upon the Healthchoice Master Payor Rate Schedules from several years as evidence of rising fees, but those schedules do not establish that provider fees have risen. The Master Payor Rate Schedules include only one of the two factors that goes into calculating a fee--the conversion factor. (FN15) They do not

include the other critical factor, which is the unit values for the more than 9,000 CPT codes. Without the unit values for the years covered by the Master Payor Rate Schedules, which Dr. Levine has not provided, the actual fees cannot be calculated. Moreover, evidence in the record indicates that Healthchoice has on many occasions lowered both the conversion factors and the unit values when its analysis of the market indicated the need for a more competitive fee structure. In any event, evidence of rising fees is insufficient unless placed in context with evidence about the fees charged by non-Healthchoice physicians, the resource costs underlying the physician services, and the rate of inflation. Thus, Dr. Levine has failed to establish a genuine issue of material fact about whether Healthchoice and CFMA have had an actual detrimental effect on competition.

[17] In the face of his failure to show an actual detrimental effect on competition, Dr. Levine argues that he still need not prove market power if he shows that the defendants intended to restrict competition. The rule of reason analysis is concerned with the actual or likely effects of defendants' behavior,

not with the intent behind that behavior. See U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir.1993) (stating that "effects are ... the central concern of the antitrust laws," and that motivation is but "a clue"). Thus even if Dr. Levine had established that the defendants intended to restrict competition--which he has not--proof of such intent would not relieve him of the necessity of either proving the defendants' market power or proving an actual detrimental effect on competition, and we have already decided that he has failed to create a genuine issue of material fact as to actual detrimental effect.

[18] In view of that, Dr. Levine's claim may only succeed under our section 1 rule of reason analysis if he proves that the defendants' acts had "the potential for genuine adverse effects on competition." To do this, Dr. Levine must define the relevant product and geographic markets and prove that the defendants had sufficient market power to affect competition. See Indiana Fed'n of Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2019. Dr. Levine contends that the relevant product market should be the

provision of internist services to Healthchoice patients, which he characterizes as an "aftermarket," relying on Eastman Kodak Co. v. Image Technical Services, Inc., 504 U.S. 451, 112 S.Ct. 2072, 119 L.Ed.2d 265 (1992), and that the relevant geographic market is the Orlando area. He argues that the product market he has defined is separate from the market for all other physician services in the Orlando area. We disagree.

[19] "To define a market is to identify producers that provide customers of a defendant firm (or firms) with alternative sources for the defendant's product or services." 2A Phillip E. Areeda et al., Antitrust Law p 530a, at 150 (1995) (footnote omitted); see also Eastman Kodak, 504 U.S. at 481, 112 S.Ct. at 2090. The "market is composed of products that have reasonable interchangeability." United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 404, 76 S.Ct. 994, 1012, 100 L.Ed. 1264 (1956); see also United States Anchor Mfg., Inc. v. Rule Indus., Inc., 7 F.3d 986, 995 (11th Cir.1993), cert. denied, --- U.S. ----, 114 S.Ct. 2710, 129 L.Ed.2d 837 (1994). Therefore, in order to provide an accurate market definition in this case, Dr. Levine

must identify the physician services that Healthchoice enrollees would deem to be reasonably interchangeable with the services provided by Healthchoice providers. It is undisputed that Healthchoice enrollees are free to choose non-Healthchoice physicians, and that Healthchoice payors will cover at least some portion of the non-Healthchoice physician's fee. Dr. *1553 Levine contends, however, that it is financially impractical for Healthchoice enrollees to visit non-Healthchoice physicians because the enrollees have to pay more money out of their own pockets to do so. Thus, he argues, non-Healthchoice internists are not interchangeable with Healthchoice internists, which means Healthchoice internists are a separate product market. We are not persuaded.

Dr. Levine has failed to present evidence showing how much more, if any, Healthchoice enrollees must pay to visit a non-Healthchoice physician. In fact, Dr. Levine admits that he has treated two Healthchoice enrollees in his practice, and that for one of those patients he waived the payor's copayment requirement so that the patient did not have an additional out-of-pocket expense. (FN16)

Moreover, Dr. Levine has offered no evidence to show that the cost to the enrollee of switching to another healthcare plan would be prohibitively expensive. Although Dr. Levine's expert assumed that Healthchoice enrollees are locked in to the Healthchoice plan, he admitted that he had seen no evidence that the enrollees' choice of plan had been so restricted. To the contrary, the evidence in the record establishes that the largest Healthchoice payor offers its enrollees several choices for healthcare coverage, and that those enrollees are allowed to switch plans. There is nothing to indicate that the other Healthchoice payors offer their enrollees any less choice. Thus, we hold that Dr. Levine's narrow definition of the relevant product market does not satisfy his burden of presenting prima facie evidence of the relevant market. (FN17) See L.A. Draper & Son v. Wheelabrator-Frye, Inc., 735 F.2d 414, 422 (11th Cir.1984) ("An antitrust plaintiff ... makes out a prima facie case under the rule of reason only upon proof of a well-defined relevant market upon which the challenged anticompetitive actions would have substantial impact." (citation and quotation marks omitted)); see also Bathke v. Casey's Gen. Stores,

Inc., 64 F.3d 340, 345 (8th Cir.1995); Pastore v. Bell Tel. Co., 24 F.3d 508, 512 (3d Cir.1994).

Even if Dr. Levine had adequately defined the relevant market, he has presented no evidence to prove the defendants' market power. Absent evidence that the defendants had sufficient market power to affect competition, Dr. Levine's section 1 claim must fail. Therefore, because Dr. Levine has not established either that the defendants' behavior had an "actual detrimental effect" on competition or "the potential for genuine adverse effects on competition," Indiana Fed'n of Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2019, we hold that the district court properly dismissed Dr. Levine's section 1 claim against Healthchoice and CFMA. (FN18)

2. The Section 1 Claim Against ORHS and Sand Lake Hospital

Dr. Levine claims that ORHS, Sand Lake Hospital, and other unnamed co-conspirators on the Sand Lake Hospital medical staff violated section 1 of the Sherman Act by conspiring to suspend his staff privileges without good cause, and

that this activity constituted a concerted refusal to deal resulting in an unreasonable restraint of trade. As Dr. Levine conceded at oral argument, the per se rule does not apply to the defendants' decision to suspend his staff privileges. As with Dr. Levine's section 1 claim against Healthchoice and CFMA, we will apply the rule of reason to his section 1 claim against ORHS and Sand Lake Hospital.

[20] We need not decide whether Dr. Levine has offered sufficient proof of a conspiracy to restrain trade between ORHS, Sand *1554 Lake Hospital, and members of its medical staff, the first element of a section 1 claim, because once again Dr. Levine has failed to demonstrate that any resulting restraint on competition is unreasonable, the second element of a section 1 claim. More particularly, Dr. Levine has not met the rule of reason's requirement of proving an actual or potential detrimental effect on competition.

The only evidence Dr. Levine offers to show that his suspension had an actual detrimental effect on competition is that one of his patients came to the Sand Lake Hospital ER during his suspension and was

unable to use Dr. Levine's services. The practical effect of this incident is no different than if Dr. Levine's patient had been taken to the ER at a hospital where he had never even applied for staff privileges--the patient would be unable to see Dr. Levine at that location at that particular time. However, had the patient gone or been taken to Florida Hospital (which has five locations), where Dr. Levine did have staff privileges, she would have been able to use Dr. Levine's services. We are convinced that a patient's inability to see Dr. Levine in the Sand Lake Hospital ER when she asked for him does not rise to the level of an actual detrimental effect on competition. Cf. Lie v. St. Joseph Hosp., 964 F.2d 567, 569-70 (6th Cir.1992) (holding that plaintiff doctor's proof that hospital staff suspension resulted in his having a lower income did not rise to level of actual detrimental effects on competition); Tarabishi v. McAlester Regional Hosp., 951 F.2d 1558, 1569 n. 15 (10th Cir.1991) (holding that plaintiff's staff privileges suspension was not an actual detrimental effect on competition because it did not result in restriction of choice to consumers or in a reduction of competition), cert. denied, 505 U.S.

1206, 112 S.Ct. 2996, 120 L.Ed.2d 872 (1992). Thus Dr. Levine's only remaining recourse for establishing his section 1 claim is to demonstrate the potential for detrimental effects on competition, and to do that he must establish that the defendants had sufficient market power to affect competition. Indiana Fed'n of Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2019.

[21] Dr. Levine maintains, however, that he need not prove the defendants' market power, and for that proposition he relies on Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991), Boczar v. Manatee Hosp. & Health Sys., Inc., 993 F.2d 1514 (11th Cir.), reh'g denied, 11 F.3d 169 (11th Cir.1993), and Bolt v. Halifax Hosp. Medical Ctr., 891 F.2d 810 (11th Cir.), cert. denied, 495 U.S. 924, 110 S.Ct. 1960, 109 L.Ed.2d 322 (1990). None of those decisions supports Dr. Levine's position.

The sole issue to be decided in Pinhas was whether a hospital's exclusion of a physician from its medical staff could satisfy the "effect on interstate commerce" jurisdictional requirement. 500 U.S. at 324, 111 S.Ct. at 1844. Dr.

Levine quotes the following language from Justice Scalia's dissent in Pinhas to support his argument: "Since group boycotts are per se violations ... [the plaintiff] need not prove an effect on competition in the Los Angeles area to prevail...." Id. at 337, 111 S.Ct. at 1851. However, this is no more than a restatement of the basic analysis under the per se rule. Because Dr. Levine has already conceded that the per se rule does not apply to his claim against the hospital, the language from Justice Scalia's dissent does not help him. Moreover, Dr. Levine ignores Justice Scalia's final position in his dissent, which is that the Sherman Act should not even apply to the hospital's actions because the hospital suspension did not affect interstate commerce. Id. at 341-43, 111 S.Ct. at 1853-54.

Dr. Levine's reliance on Bolt is no more persuasive. He interprets Bolt to stand for the proposition that, in his words, "there was no requirement to prove [market definition or market share] when there is evidence of anticompetitive intent." Dr. Levine's interpretation of Bolt misses the point that our focus in that opinion was only on the first element of the section 1

claim--whether there was sufficient evidence of a contract, combination, or conspiracy to submit to the jury. 891 F.2d at 818, 829. We held that as to some of the defendants, there was sufficient evidence of a conspiracy to go to the jury, and thus remanded the case to the district court. All discussion of intent in Bolt was in the context of its value as circumstantial evidence of the existence of an agreement. *1555 Id. at 819-20. As to the second element of the section 1 claim in Bolt, we explained that the district court had granted a motion for directed verdict "before [the plaintiff] reached that part of his case involving restraint on competition." Id. at 829. We criticized the district court's premature ruling and stated that "[t]he better course would have been to defer ruling on the motions for directed verdict until after [the plaintiff] had presented his entire section 1 case." Id. at 828. If anything, Bolt is inconsistent with Dr. Levine's position that he should be relieved of proving market power.

His reliance on Boczar is equally misplaced. In Boczar, we reviewed the district court's grant of a post-verdict

motion for judgment as a matter of law in favor of the defendants based on its finding that there was insufficient evidence of a conspiracy. We reversed the district court and held that the plaintiff had presented sufficient evidence to support the jury's verdict. 993 F.2d at 1519. As to the anticompetitive effect element of the plaintiff's case, we simply observed--without discussing the evidence that had been presented at trial--that the defendants' actions had "effectively ended [the plaintiff's] ability to compete and to practice ... and burdened her ability to compete generally." Id. That was nothing more than a fact-specific observation that the plaintiff in Boczar had proven anticompetitive effect. By contrast, the record in this case establishes beyond legitimate dispute that Dr. Levine's ability to compete and practice have flourished. Nothing in Boczar supports his position that he need not prove the defendants' market power.

In order to prevail in a rule of reason case, absent a demonstrated adverse effect on competition, a plaintiff must define the market and prove that the defendants had sufficient market power to adversely affect competition. See Indiana Fed'n of

Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2019. Because he has offered no evidence defining the relevant product or geographic market, and because he has not established ORHS's or Sand Lake Hospital's market power, the district court properly granted summary judgment to the defendant on this section 1 claim.

B. THE SECTION 2 CLAIMS

[22][23] In Count 2 of his complaint Dr. Levine claimed that CFMA monopolized, attempted to monopolize, and conspired with Healthchoice, ORHS, and Sand Lake Hospital to monopolize the market for physician medical services to Healthchoice enrollees in the Orlando area in violation of section 2 of the Sherman Act. (FN19) "The offense of monopoly under Sec. 2 of the Sherman Act has two elements: (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." United States v. Grinnell Corp., 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1704, 16 L.Ed.2d 778 (1966); see also T. Harris Young & Assocs., Inc. v.

Marquette Elec., Inc., 931 F.2d 816, 823 (11th Cir.), cert. denied, 502 U.S. 1013, 112 S.Ct. 658, 116 L.Ed.2d 749 (1991); Austin v. Blue Cross & Blue Shield, 903 F.2d 1385, 1391 (11th Cir.1990). "Monopoly power under Sec. 2 requires, of course, something greater than market power under Sec. 1." Eastman Kodak, 504 U.S. at 480, 112 S.Ct. at 2090.

[24][25] To establish a violation of section 2 for attempted monopolization, "a plaintiff must show (1) an intent to bring about a monopoly and (2) a dangerous probability of success." Norton Tire Co. v. Tire Kingdom Co., 858 F.2d 1533, 1535 (11th Cir.1988).

> To have a dangerous probability of successfully monopolizing a market the defendant must be close to achieving monopoly power. Monopoly power is "the power to raise prices to supra-competitive levels or ... the power to exclude competition in the relevant market either by restricting entry of new competitors or by driving existing competitors out of the market." *1556. United States Anchor Mfg., 7 F.3d at 994 (quoting American Key Corp. v. Cole Nat'l Corp., 762 F.2d 1569, 1581 (11th

Cir.1985)). A claim for conspiracy to monopolize, on the other hand, does not require a showing of monopoly power. Instead, a plaintiff proves a section 2 conspiracy to monopolize by showing: "(1) concerted action deliberately entered into with the specific intent of achieving a monopoly; and (2) the commission of at least one overt act in furtherance of the conspiracy." Todorov, 921 F.2d at 1460 n. 35.

Although Dr. Levine's complaint is somewhat ambiguous, it appears that he is alleging all three types of claims--monopolization, attempted monopolization, and conspiracy to monopolize--only against CFMA. Healthchoice, ORHS, and Sand Lake Hospital are each alleged only to have conspired to monopolize the relevant market. Even assuming that Dr. Levine is alleging that all four defendants are liable for all three section 2 claims, the defendants are entitled to summary judgment as a matter of law.

[26] Proof of monopoly power in the relevant market is the first element of a monopolization claim, and proof that there is a dangerous probability of the defendant successfully attaining monopoly

power is the second element of an attempted monopolization claim. Dr. Levine's failure to adequately define the relevant market, and his failure to prove that the defendants possessed or were close to possessing monopoly power in that relevant market, are fatal to his section 2 claims for monopolization and for attempted monopolization. Moreover, as to his claim for conspiracy to monopolize, Dr. Levine has presented no evidence that the defendants possessed a specific intent to monopolize, which is the first element of a conspiracy to monopolize claim, when they denied him membership or when they suspended his staff privileges. Because Dr. Levine has failed to establish a genuine issue of material fact as to necessary elements of these section 2 claims, we affirm the district court's grant of summary judgment in favor of the defendants as to these claims. (FN20)

IV. CONCLUSION

The district court's grant of summary judgment in favor of the defendants is AFFIRMED.

FN* Honorable Wilbur D. Owens, Jr., Senior U.S. District Judge for the Middle District of Georgia, sitting by

designation.

FN1. One physician offered Dr. Levine $60,000 a year plus benefits, and another offered him $100,000 a year plus benefits. Neither offer appealed to Dr. Levine.

FN2. ORHS was formerly known as the Orlando Regional Medical Center, a name the organization shared with one of its unincorporated hospital facilities.

FN3. Healthchoice is owned by Healthnet Services, Inc., which is a for-profit wholly owned subsidiary of ORHS.

FN4. For a detailed description of how Healthchoice and CFMA operate, see infra pp. 1552-1553.

FN5. Dr. Levine's staff privileges at Sand Lake Hospital included the privilege of admitting patients to the hospital and treating them during their stay, and the privilege of being on ER call and treating patients through the ER.

FN6. Dr. Levine alleges that his staff privileges were suspended at ORMC as well as Sand Lake Hospital; however, we have found no evidence in the record to support

that allegation.

FN7. In addition to the federal antitrust claims, Dr. Levine's complaint included the following: claims under Florida's antitrust statutes; a claim for tortious interference with business relations; a claim under Florida's general tort statute; and a claim for breach of contract. Dr. Levine filed a parallel suit in state court which has been held in abeyance pending resolution of this case in federal court.

FN8. Counts 1 through 3 also included Dr. Levine's state antitrust law claims.

FN9. Section 4 of the Clayton Act authorizes a private action for treble damages and provides, in pertinent part: "[A]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor ...." 15 U.S.C.A. Sec. 15(a) (West 1995). Section 16 authorizes a private action for injunctive relief, and provides, in pertinent part: "Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties,

against threatened loss or damage by a violation of the antitrust laws ...." 15 U.S.C.A. Sec. 26 (West 1973).

FN10. Because we hold that Dr. Levine has failed to establish any antitrust violation, we also need not consider whether he has established standing to sue for injunctive relief under section 16 of the Clayton Act.

FN11. Healthchoice charges each payor a nominal monthly fee for each of the payor's enrolled employees. In 1994, the fee was approximately $1.25 per month for each enrollee. Healthchoice has never earned a profit.

FN12. "Covered lives" includes enrolled employees and any family members covered by their policy. The parties define "the Orlando area" as Orange, Seminole, and Osceola counties.

*1556_

FN13. We also note that in Arizona v. Maricopa County Medical Soc'y, the Supreme Court implicitly sanctioned this approach to negotiating reimbursement rates:

> [A] binding assurance of complete insurance coverage--as well as most of the respondents' potential for lower insurance premiums--can be obtained only if the insurer and the doctor agree in advance on the maximum fee that the doctor will accept as full payment for a particular service. Even if a fee schedule is therefore desirable, it is not necessary that the doctors do the price fixing.... [I]nsurers are capable not only of fixing maximum reimbursable prices but also of obtaining binding agreements with providers guaranteeing the insured full reimbursement of a participating provider's fee.
>
> 457 U.S. 332, 352-53, 102 S.Ct. 2466, 2477-78, 73 L.Ed.2d 48 (1982) (footnote omitted).

FN14. For a discussion of market power, see infra pp. 776-78.

FN15. For an explanation of how the fees are calculated, see supra pp. 769-70.

FN16. Dr. Levine says that this patient stopped seeing him because she felt too guilty about his having waived the copayment requirement. That purported

reason is somewhat ironic in view of Dr. Levine's income level. See supra p. 776.

FN17. Dr. Levine was required to define both the relevant product market and the relevant geographic market; however, because we have held that he failed to adequately define the relevant product market, we need not reach whether the Orlando area is a proper relevant geographic market.

FN18. Because we hold that Dr. Levine has failed to establish any anticompetitive effect, we need not reach the second part of the rule of reason analysis and decide whether the defendants' conduct may be excused by some procompetitive benefit or justification.

FN19. Section 2 provides that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony." 15 U.S.C.A. Sec. 2 (West 1973).

FN20. We also reject Dr. Levine's argument that the district court erroneously

granted summary judgment against him on his state law antitrust claims. Florida's statute regulating combinations in restraint of trade provides: "It is the intent of the Legislature that, in construing this chapter, due consideration and great weight be given to the interpretations of the federal courts relating to comparable federal antitrust statutes." Fla.Stat.Ann. Sec. 542.32 (West 1988); see also All Care Nursing Serv., Inc. v. Bethesda Memorial Hosp., Inc., 887 F.2d 1535, 1539 n. 1 (11th Cir.1989) (Tjoflat, J. concurring); Ad-Vantage Tel. Directory Consultants, Inc. v. GTE Directories Corp., 849 F.2d 1336, 1340 (11th Cir.1987) ("In applying this provision, the Florida courts held that the Florida legislature has, in effect, adopted as the law of Florida the body of anti-trust law developed by the federal courts under the Sherman Act. St. Petersburg Yacht Charters, Inc. v. Morgan Yacht, Inc., 457 So.2d 1028 (Fla.App.1984). Thus, in analyzing this case, we may, and indeed must, apply the federal precedent developed under Section 2 of the Sherman Act."). Therefore, the district court's grant of summary judgment on the state law antitrust claims was proper for the same reasons its grant of

summary judgment on the federal antitrust claims was proper.

APPENDIX B - OPINION OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRIC OF FLORIDA, ORLANDO DIVISION FILED AUGUST 31, 1994 (864 F.Supp. 1175)

Scott D. LEVINE, M.D., Plaintiff,
v.
CENTRAL FLORIDA MEDICAL AFFILIATES, INC., Healthchoice, Inc., Sand Lake Hospital and Orlando Regional Healthcare System, Inc. f/k/a Orlando Regional Medical Center, Defendants.
No. 93-153-Civ-Orl-22.
United States District Court,
M.D. Florida,
Orlando Division.
Aug. 31, 1994.
ORDER

CONWAY, District Judge.

This cause comes before the Court for consideration of the motions for partial summary judgment filed by the Defendants in this case. In deciding the motions, the Court has considered all materials timely filed by the parties.

I. Facts

Defendant Orlando Regional Healthcare Systems, Inc. ("ORHS"), which was formerly known as Orlando Regional Medical Center, is a not-for-profit organization that owns and operates Orlando Regional Medical Center (located in downtown Orlando) ("ORMC"), Arnold Palmer Hospital for Children and Women, and Defendant Sand Lake Hospital ("Sand Lake").

Healthnet Services, Inc. is a wholly owned for-profit subsidiary of ORHS. Healthnet owns Defendant Healthchoice, Inc. ("Healthchoice "). Healthchoice is a preferred provider organization ("PPO") which presently has approximately 68,000 enrollees. Healthchoice competes with other PPOs, health maintenance organizations ("HMOs") and traditional comprehensive insurance coverage ("TCIC") companies to provide health care coverage in the Orlando area (Orange, Seminole and Osceola Counties), which presently has a population of approximately 1,139,000. Healthchoice enters into contracts with employers, insurers, and other payors to provide comprehensive health care coverage for employees, insureds and other beneficiaries.

Defendant Central Florida Medical Affiliates, Inc. ("CFMA") primarily acts as a physician advocacy group. Its members, who must be Healthchoice provider panel members, work with Healthchoice to attempt to ensure that the administrative practices of Healthchoice, including utilization reviews and reimbursement procedures, are acceptable to physician members of the provider panel. It is not, however, necessary to be a member of CFMA to be a participating physician on the

Healthchoice provider panel, and numerous physician panel members of Healthchoice are not members of CFMA.

PPOs, such as Healthchoice, are comprised of a network of healthcare providers, including physicians and hospitals. Some PPOs, including Healthchoice, use a limited or closed panel of providers. Healthchoice determines the size of its provider panel under a need analysis system. Utilizing recognized industry standards, the number of physicians on the panel are determined by a number of factors, including: 1) the number of enrollees in the plan; 2) the geographic location of enrollees and physician panel members; 3) the specialty areas in which the physician panel members practice; 4) the administrative cost of operating the plan; and 5) special needs of particular payors. Healthchoice asserts that it strives to have the right number of qualified physicians on its closed panel to meet the needs of enrollees, while providing panel members with a sufficient patient base to induce them to provide services for lower fees.

*1178 Plaintiff is a physician, specializing in internal medicine. He graduated from Wayne State University with an M.D. degree in 1985. He did an

internship and a residency in internal medicine at the UCLA/San Fernando Valley Program. He moved to Orlando, Florida in the fall of 1989. On September 25, 1989, he was granted provisional staff privileges at both ORMC and Sand Lake. On November 12, 1990, he was granted active staff privileges at both hospitals.

In November 1990, Plaintiff inquired into the possibility of joining CFMA and Healthchoice. He was informed that there were already enough internists in his quadrant of the city to meet Healthchoice member needs. Plaintiff then hired an attorney to inquire about admission to CFMA and Healthchoice.

On January 11, 1991, Plaintiff's emergency room privileges at Sand Lake were suspended. Shortly thereafter, his other medical staff privileges were suspended. [FN1] Those privileges were reinstated, subject to certain conditions, in May 1991.

> FN1. Plaintiff, in his Complaint, clearly alleges that his privileges were suspended at both ORMC and Sand Lake. However, documents filed recently by the parties suggest that Plaintiff was only suspended at Sand Lake. The Court's analysis is the

> same, whether Plaintiff's privileges were suspended at both hospitals or only one. The Court assumes, for the purpose of deciding the pending motions, that Plaintiff's privileges were suspended at both ORMC and Sand Lake.

Plaintiff has brought this suit asserting federal antitrust claims and pendant state claims.

II. Count III: Concerted Refusal to Deal

Plaintiff asserts that Sand Lake, ORMC and another internist conspired to blacklist Plaintiff by summarily suspending his staff and emergency room privileges and circulating to other doctors the notice of his suspension. This conspiracy allegedly violates Section 1 of the Sherman Act, 15 U.S.C. s 1. That section provides, in relevant part, that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." Sand Lake and ORHS have filed a Motion for Partial Summary Judgment (Dkt. 58) in which they argue that Plaintiff lacks standing and, alternately, that Plaintiff cannot establish a conspiracy in restraint of

trade.

a. Standing

[1] The Eleventh Circuit has identified a two-pronged approach to determine whether a plaintiff has antitrust standing. To be a proper party, a plaintiff must have suffered an antitrust injury and must be an efficient enforcer of the antitrust laws. Thompson v. Metropolitan Multi-List, Inc., 934 F.2d 1566, 1571 (11th Cir.1991), cert. denied, --- U.S. ----, 113 S.Ct. 295, 121 L.Ed.2d 219 (1992); Todorov v. DCH Healthcare Authority, 921 F.2d 1438, 1449 (11th Cir.1991).

[2][3] Antitrust injury is defined as:

> injury of the type the antitrust laws were intended to prevent and that flows from that which makes the defendants' acts unlawful. The injury should reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation. It should, in short, be 'the type of loss that the claimed violations ... would be likely to cause.'

Todorov, 921 F.2d at 1449 (quoting Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 489, 97 S.Ct. 690, 697, 50 L.Ed.2d 701 (1977)). The plaintiff must show that his injury

coincides with " 'the public detriment tending to result from the alleged violation ... increas[ing] the likelihood that public and private enforcement of the antitrust laws will further the same goal of increased competition.' " Todorov, 921 F.2d at 1450 (quoting Austin v. Blue Cross & Blue Shield, 903 F.2d 1385, 1389-90 (11th Cir.1990)).

In addition to establishing an antitrust injury, a plaintiff must be an efficient enforcer of the antitrust laws. To determine whether a party is an efficient enforcer, a court must consider a variety of factors set forth by the Supreme Court in Associated General Contractors, Inc. v. California State Council of Carpenters, 459 U.S. 519, 103 S.Ct. 897, 74 L.Ed.2d 723 (1983). Todorov, 921 F.2d at 1450-52.

*1179 [4] Defendants assert that, even if Plaintiff can establish a personal injury, he cannot establish an antitrust injury. They note that Plaintiff was suspended for a period of about five months. During this period of time, Plaintiff had staff privileges at Florida Hospital's several campuses, Charter Hospital and Glenbeigh. Through these other hospitals, Plaintiff had access to 1,623 licensed beds. Immediately after his suspension, Plaintiff began using Florida Hospital for

the hospitalization of his patients. Therefore, there was a change in the location at which some patients received services, but there was no decrease in services available to consumers of medical services. There was no decrease in the number of internists practicing in the Orlando area. There is no indication that Plaintiff's suspension had any effect on the price of services rendered. Defendants argue, therefore, that Plaintiff cannot establish an antitrust injury.

In response, Plaintiff identifies the injuries that he has suffered. Plaintiff states that his suspension was a black mark on his career, which resulted in Plaintiff being blacklisted and precluded from working with doctors, the emergency room and patients. [FN2] Plaintiff's suspension was reported to Florida's Department of Professional Regulation. The suspension resulted in a stigma and difficulty regarding privileges at other hospitals. [FN3] Finally, Plaintiff suggests that he has lost income from his suspension. Plaintiff argues that under applicable caselaw, these injuries are sufficient to satisfy standing requirements.

FN2. Since Plaintiff had staff privileges and was able to admit patients at other hospitals, the Court assumes that Plaintiff's injury was his inability to work with doctors, the emergency room and patients at Sand Lake and ORMC.

FN3. To support his assertion that the Florida Department of Professional Regulation was notified and that he subsequently had difficulty regarding privileges at other hospitals, Plaintiff cites certain documents by referring to their Bates numbers. After a diligent review of all documents submitted by the parties, the Court has been unable to locate these documents. For the purpose of deciding the pending motions, the Court assumes that Plaintiff's assertions are true.

The first case on which Plaintiff relies is Bolt v. Halifax Hospital Medical Center, 891 F.2d 810 (11th Cir.1990), cert. denied, 495 U.S. 924, 110 S.Ct. 1960, 109 L.Ed.2d 322 (1990). In Bolt, the court held that "a hospital and the members of its medical staff are all

legally capable of conspiring with one another." Id. at 819. The next question before the court was whether at trial on the merits, plaintiff established that the defendants actually did conspire. The court did not specifically address whether the plaintiff had suffered an antitrust injury and therefore had standing to sue. Plaintiff suggests that the standing requirement was clearly satisfied in Bolt since the court did not find it necessary to address that issue. In interpreting and applying caselaw, there is a certain danger inherent in assuming that an issue not presented to and addressed by the court has been decided. Nonetheless, the Court will make this assumption in order to assess the argument made by Plaintiff. Assuming that the plaintiff in Bolt did have standing to bring an antitrust claim, the Court must identify the nature of the injury suffered which constituted an "antitrust injury."

The plaintiff in Bolt was a physician who was denied reappointment and suspended by three different executive committees at three different hospitals in Daytona Beach, Florida. In discussing whether the Defendants actually did conspire, the court stated that doctors in a hospital may be motivated to exclude other doctors.

The exclusion allows the doctors who remain to charge higher prices. Id. at 820. The court went on to observe:

> [A] negative decision at one hospital could affect the decision at another hospital; therefore ... a negative decision by one hospital could be 'tantamount to excluding a doctor from the profession as a whole.' Given the ability of a single peer review committee to control the supply of doctors not only at one hospital but also in the profession as a whole, we conclude that there existed a rational economic motive for the DCH defendants to conspire to deny Dr. Bolt's hospital privileges.

Id. (citation omitted). This analysis, which suggests an economic motive for conspiracy, *1180 also suggests the type of antitrust injury that may result from a conspiracy. In fact, the plaintiff in Bolt did find himself unable to practice at three different hospitals. It appears that the Plaintiff was effectively removed from competition and the total number of doctors available to render service was reduced. However, this type of information was never fully developed since the trial court had considered only the issue of conspiracy. Id. at 828.

While Bolt suggests the type of antitrust injury that may result from a conspiracy in restraint of trade, the facts of the case before the Court do not support the existence of such an injury. During the time his privileges were suspended at Sand Lake and ORMC, Plaintiff was able to admit patients to several other hospitals. An antitrust injury could have been the result of Plaintiff's suspension. But that possibility does not automatically lead to a conclusion that an antitrust injury did result.

Plaintiff also relies on Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991). In Pinhas the Supreme Court addressed the very limited question of whether the interstate commerce requirement of antitrust jurisdiction is satisfied by allegations that a hospital, its staff and others conspired to exclude a physician from the market for his specialized medical services. The Supreme Court held that the interstate commerce jurisdictional requirement was satisfied, based on the allegations in the complaint. The Court did not directly address the type of antitrust injury that would satisfy a standing requirement. However, Justice Scalia, writing for the dissent, observed

that the defendant hospital had "effectively excluded [the doctor] from the entire Los Angeles market for eye surgery (because no other Los Angeles hospital would accord him practice privileges after [the defendant hospital] rejected him)." Id. at 336, 111 S.Ct. at 1850. Once again, the situation for Plaintiff in the case at bar is very different from the situation described in Pinhas.

Finally, Plaintiff refers the Court to Boczar v. Manatee Hospitals & Health Systems, Inc., 993 F.2d 1514 (11th Cir.1993). In Boczar the Eleventh Circuit reviewed the record from the trial court to determine whether the evidence supported the existence of a conspiracy. Once again the Eleventh Circuit did not directly address the issue of antitrust injury and the case provides only limited guidance on this critical issue. In Boczar, the doctor's staff privileges were suspended at only one hospital. On the surface it would appear that action by one hospital is sufficient to establish antitrust injury. However, the court noted that the hospital "effectively ended [the doctor's] ability to compete and to practice in Bradenton and burdened her ability to compete generally." Id. at

1519.

Plaintiff in the case before the Court cannot make such a claim. He has successfully competed and practiced in the Orlando area. Whatever may be said about his personal injuries, his suspension from ORMC and Sand Lake does not constitute an antitrust injury. Therefore, he lacks standing to bring a claim under Section 1 of the Sherman Act.

b. Conspiracy in Restraint of Trade

[5] Even if the Court were to assume that Plaintiff has standing to bring a Section 1 claim, Defendants would prevail on their motion for summary judgment. "The elements of a conspiracy to restrain trade under Section 1 are (1) an agreement to enter a conspiracy (2) designed to achieve an unlawful objective. The plaintiff must also prove (3) 'actual unlawful effects [or] facts which radiate a potential for future harm' to competition." U.S. Anchor Mfg., Inc. v. Rule Industries, Inc., 7 F.3d 986, 1001 (11th Cir.1993) (citations omitted), cert. denied, --- U.S. ----, 114 S.Ct. 2710, 129 L.Ed.2d 837 (1994). See also Bolt v. Halifax Hospital Medical Center, 891 F.2d 810, 820 (11th Cir.1990) (requiring a plaintiff to prove 1) an intent to adhere to an agreement; 2) which was not designed to achieve a

legitimate business purpose; and 3) which had an anticompetitive effect).

As stated above, the Eleventh Circuit has held that a hospital and the members of its medical staff are all legally capable of conspiring *1181 with one another. [FN4] Bolt, 891 F.2d at 819. A hospital and its staff may have economic reasons to conspire to suspend staff privileges for a doctor. Id. at 820; Boczar v. Manatee Hospitals & Health Systems, Inc., 993 F.2d 1514, 1518 & n. 10 (11th Cir.1993). Evidence of inconsistencies in the review process and of unfair treatment may exclude the possibility that the hospital and its staff pursued the review for purely legitimate ends. Boczar, 993 F.2d at 1519 n. 12. Therefore, a doctor may establish the first two elements of a Section 1 claim by attacking the peer review process and by presenting evidence that suggests the review was a sham and pretextual. For the purpose of deciding Defendants' motion, the Court will assume that Plaintiff can establish the first two elements of a Section 1 claim. [FN5] The task before the Court is to determine whether the actions of ORMC and Sand Lake have resulted in an anticompetitive effect. [FN6]

FN4. Plaintiff appears to misunderstand the holding in Bolt. A holding that a hospital and its staff have the legal capacity to conspire does not mean that every action taken by the hospital and its staff will satisfy the conspiracy requirements. A plaintiff must still prove that the members actually did conspire. Bolt, 891 F.2d at 819.

FN5. The Court's review of the first two elements has been significantly hindered by Plaintiff's failure to provide at least a page cite to a number of depositions filed in support of his response. As a practical matter, the Court simply does not have the time to track down statements that purportedly create a disputed issue of fact. Faced with this dilemma, the Court has chosen to assume the first two elements are satisfied.

FN6. Requiring a plaintiff to establish the existence of an anticompetitive effect in order to prevail on the merits is similar to requiring a plaintiff to show an antitrust injury in order to

establish standing.

[6] Defendants have argued that evidence of an anticompetitive effect or, alternately, evidence of a potential to harm future competition, generally require a plaintiff to show that the defendant(s) had market power in the relevant product and geographic markets. In support of their argument, Defendants refer the Court to Lie v. St. Joseph Hospital, 964 F.2d 567 (6th Cir.1992). In Lie the Sixth Circuit summarized Supreme Court caselaw that provides a structure for analyzing whether an agreement unreasonably restrains trade. If an agreement is plainly anti-competitive, it is considered a "per se " antitrust violation. Id. at 569. If an agreement is illegal per se, the plaintiff does not have to establish proof of defendants' market power. Id. However, there are very few classes of conduct that are illegal per se. Capital Imaging Associates v. Mohawk Valley Medical Associates, Inc., 996 F.2d 537, 542 (2d Cir.1993), cert. denied, --- U.S. ----, 114 S.Ct. 388, 126 L.Ed.2d 337 (1993). Examples of per se violations include horizontal and vertical price-fixing, division of a market into territories, certain tying arrangements,

and some group boycotts involving concerted refusal to deal with a competitor. Id. at 542-43. As the Second Circuit noted in Capital Imaging, "[i]n discussing group boycotts the Supreme Court cautions against application of the per se rule against professional associations because the economic impact of professional activities is so difficult to track." Id. at 543 (citing FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 458-59, 106 S.Ct. 2009, 2017-18, 90 L.Ed.2d 445, 457 (1986)).

[7] Most antitrust violations do not fall within the limited categories of per se violations. Instead, a plaintiff must prove the existence of an antitrust injury under a "rule of reason" analysis. Id. The purpose of the rule of reason analysis is to determine whether a restraint regulates and promotes competition or whether it suppresses competition. Lie, 964 F.2d at 569. This determination usually requires an inquiry into market definition and market power. Id.

There is one exception to the usual requirement that a plaintiff establish market power as part of the rule of reason analysis. If the antitrust violation involves " 'a naked restriction on price or output' " or, similarly, if a plaintiff

can provide " 'proof of actual detrimental effects,' " failure to prove market power will not defeat a plaintiff's claim. Id. at 569-70 (quoting Indiana Fed'n of Dentists, 476 U.S. at 460-61, 106 S.Ct. at 2018- 19).

*1182 [8] Plaintiff has suggested that this case involves a group boycott, which traditionally has been categorized as a per se violation. The Court is not persuaded that the facts presented are consistent with the traditional group boycott situation. Upon review of relevant caselaw, the Court concludes that the proper analysis in this case is the rule of reason. Indiana Fed'n of Dentists, 476 U.S. at 458-59, 106 S.Ct. at 2017-18. The next question is whether this case is an exceptional one in which actual detrimental effects on competition have been established so that the Plaintiff is not required to establish market power. As set forth above, Plaintiff has not established that his suspension had any effect whatsoever on competition. Therefore, he is not relieved of his obligation to establish market power. As Defendants note, Plaintiff has not attempted to define the relevant market or provide evidence of market power. He has, therefore, failed to present evidence

critical to his claim.

Plaintiff has argued that caselaw establishes that he has suffered an antitrust injury as a matter of law. The Court cannot agree. In Summit Health, Ltd. v. Pinhas, the Supreme Court addressed a threshold issue related to jurisdiction. 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991). The Supreme Court never reached the elements of a Section 1 claim. Similarly, in Bolt v. Halifax Hospital Medical Center, the Eleventh Circuit never addressed the issue of whether the defendants' actions actually restrained competition. 891 F.2d 810, 829 (11th Cir.1990). By contrast, in Boczar v. Manatee Hospitals & Health Systems, Inc., the Eleventh Circuit did address the issue of whether the plaintiff had established an anti-competitive effect. 993 F.2d 1514 (11th Cir.1993). The court stated that the hospital "effectively ended [the doctor's] ability to compete and to practice in Bradenton." Id. at 1519. It appears that the plaintiff in that case established the existence of an actual detrimental effect on competition. Once again, when a plaintiff has made such a showing, a failure to establish market power is not fatal to plaintiff's case. The Plaintiff,

in his case, has made no such showing. After his suspension, he went on to compete effectively in Orlando. Unlike the plaintiff in Boczar, Plaintiff must establish market power in order to maintain a claim under Section 1. This he has not done. Therefore, his claim must fail.

Under the facts of this case, Plaintiff has failed to establish an antitrust injury, and, therefore, he lacks standing to bring his claim. Alternately, he has failed to establish an anti-competitive effect, and, therefore, his claim must fail on the merits. Defendants are entitled to summary judgment on the federal antitrust claims in Count III of Plaintiff's Complaint.

III. Count I: Conspiracy to Unreasonably Reduce The Availability of and Competition in Services to Consumers of Medical Services and Count II: Monopolization, Attempt to Monopolize, Conspiracy to Monopolize.

The parties agree that Plaintiff has expressed an interest in becoming a member of CFMA and a provider of services for Healthchoice. CFMA and Healthchoice have indicated there is no need for Plaintiff's services. Based on these events, Plaintiff asserts that CFMA, Healthchoice,

ORMC and Sand Lake have monopolized, attempted to monopolize and conspired to monopolize the provision of medical services by physicians and hospitals to patient members of Healthchoice (product market), in the Orlando, Florida area (geographic market) in violation of Section 2 of the Sherman Act, 15 U.S.C. s 2. [FN7] Additionally, Plaintiff asserts that CFMA, Healthchoice and the member doctors of CFMA have conspired to unreasonably restrict the availability of and competition among healthcare providers for the consumers of Healthchoice in violation of Section 1 of the Sherman *1183 Act, 15 U.S.C. s 1. [FN8] According to Plaintiff, "[e]mployees whose employers have contracted with Healthchoice practically will not and do not purchase medical services from physicians who are not members of CFMA," and "CFMA doctors provide virtually 100% of all medical services to consumers of Healthchoice." Complaint (Dkt. 1), paras. 19, 34. CFMA and Healthchoice have filed separate Motion[s] for Partial Summary Judgment (Dkts. 47 and 61, respectively) in which they argue that Plaintiff lacks standing to bring these claims and, alternately, that Plaintiff cannot establish the elements required for either a Section 1

or a Section 2 claim.

> FN7. Section 2 of the Sherman Act provides:
> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.
> 15 U.S.C. s 2.

> FN8. For the text of Section 1 of the Sherman Act, see Section II.

a. Standing

As set forth in Section II.a., the Eleventh Circuit has identified a two-pronged approach to determine whether a plaintiff has antitrust standing. A plaintiff 1) must have suffered an antitrust injury and 2) must be an

efficient enforcer of the antitrust laws. Todorov v. DCH Healthcare Authority, 921 F.2d 1438, 1449 (11th Cir.1991).

[9] The inquiry into whether a plaintiff is an efficient enforcer of the antitrust laws requires a court to consider several different factors. Id. at 1451. One factor is the "directness of the asserted injury in a causal sense." Id. If there is " 'an identifiable class of persons whose self- interest would normally motivate them to vindicate the public interest in antitrust enforcement,' ", a party with an indirect injury may not be the proper party to enforce the antitrust laws. Id. (quoting Associated Gen. Contractors, Inc. v. California State Council of Carpenters, 459 U.S. 519, 542, 103 S.Ct. 897, 910, 74 L.Ed.2d 723 (1983)). A second factor is the nature of the plaintiff's damages claims. Id. If the claims are highly speculative, the plaintiff may not have standing. Finally, a court should review a plaintiff's claim in light of the overarching goal of keeping antitrust litigation within " 'judicially manageable limits.' ". Id. (quoting Associated Gen., 459 U.S. at 543, 103 S.Ct. at 911). With this goal in mind, a court should avoid "duplicative recoveries and the danger of complex

apportionment of damages." Id. Upon review of these factors, a court may determine whether "a particular plaintiff will efficiently vindicate the goals of the antitrust laws." Id. at 1452.

In Todorov, the plaintiff, a neurologist, applied for the privilege of administering and interpreting CT scans of the head. Id. at 1441-43. At the time the plaintiff applied for this privilege, CT scans were administered by the defendant hospital's radiology department. After a CT scan was administered, a radiologist would interpret the film for the patient's treating physician. In connection with his practice, the plaintiff usually examined the film for his patients after the interpretation by the radiologist. However, the plaintiff had difficulty collecting a fee for his examination from insurance companies because most companies would pay only one fee. That fee went to the radiologist who made the official interpretation. The plaintiff sought the privilege of administering CT scans in order to claim the fee for interpretation of the film. The hospital denied his application.

After elaborating on the two-pronged test for standing, the court in Todorov conducted an economic analysis of the

market for administering CT scans. Id. at 1452-54. The plaintiff had alleged that the radiologists were reaping monopoly profits. The court noted that the plaintiff had applied for privileges so that he could share in those same profits. Id. In effect, the plaintiff was trying to use the antitrust laws as a means to gain benefits based on anticompetitive conduct. The court concluded that "[t]his is not antitrust injury. The antitrust laws were not enacted to permit one person to profit from the anticompetitive behavior of another person." Id. at 1454.

[10] In the case at hand, the Court assumes, solely for the purpose of deciding the motions for summary judgment, that the closed panel PPO that Healthchoice operates is an illegal restriction that violates the antitrust laws. Given that assumption, it appears to the Court that Plaintiff's primary goal is to share in the "illegal profits" that CFMA members enjoy. In one of his depositions, *1184 Plaintiff was asked how much money he thought he would have made if he had been a member of CFMA. Plaintiff responded, "I haven't sat down with a pencil and paper and tried to figure it out. But I figured, with what everyone else is telling me, I could have

done 20 percent better." Levine Deposition, 12/6/93, p. 468. Plaintiff's expectation is rooted in an assumption that his application would be accepted, and that he would serve on an equal footing with all other doctors on the closed panel. Only in this manner could Plaintiff reasonably expect to increase his income by 20 percent. Plaintiff's situation is identical to the plaintiff's situation in Todorov. He hopes to benefit from the Defendant's allegedly anticompetitive conduct. This Court must echo the Eleventh Circuit in concluding that "[t]his is not antitrust injury. The antitrust laws were not enacted to permit one person to profit from the anticompetitive behavior of another person." Id.

Counsel for Plaintiff vehemently denies that Plaintiff seeks to keep Healthchoice a closed panel. Brief in Opposition to Motions for Partial Summary Judgment (Dkt. 91), p. 16. In his affidavit, Plaintiff states, "I did not and do not feel that Healthchoice and CFMA should be closed to any qualified license[d] doctors. It is and has been my view that Healthchoice and CFMA should be open to all licensed physicians, so as to give consumers in Healthchoice unrestricted choice in

medical care providers." Affidavit of Scott D. Levine, M.D. (Dkt. 112), para. 13. See also Complaint (Dkt. 1), para. 26. It is not within the province of the Court to determine the credibility of testimony when evaluating the merits of a motion for summary judgment and the response thereto. Accordingly, for the purpose of deciding the pending motions, the Court will accept at face value Plaintiff's argument that the remedy he seeks is an open panel and analyze whether Plaintiff is the proper party to bring such a claim.

The difficulty with Plaintiff's argument is that, even if Healthchoice were open to all doctors, there is no way to calculate the effect on Plaintiff's practice. Plaintiff states that the success of his business is due to the excellent care he renders and the attention to the patient he provides for a fair price. Id. He states:

> My success in general by using this approach would have carried over to me being very successful in caring for Healthchoice patients. If my income far exceeds that of other internists in Orlando, it is because I provide excellent care for a fair price. Those same factors would likely cause me to

far exceed the income of other internists in caring for Healthcare patients if Healthchoice and CFMA were open to me and other providers of medical care.

Id. For the sake of deciding the pending motions, the Court assumes Plaintiff would be more successful, financially speaking, than all other internists if Healthchoice were an open panel PPO. The question before the Court is whether the increase in his practice could be quantified.

There are currently 2,200 licensed physicians in the Orlando area. Healthchoice presently has 863 physicians on its provider panel in Orange, Seminole and Osceola Counties. It is impossible to predict how many of the doctors not currently on the panel would choose to participate in Healthchoice. The Defendants have argued that, at this time, doctors are willing to accept a lower price for services rendered to Healthchoice patients because the closed panel ensures that doctors will have a relatively high volume of patients. If Healthchoice is an open panel, doctors may be disinclined to join the PPO. For example, Plaintiff has not joined a variety of HMOs and PPOs because he does not see an economic advantage to belonging

to those managed care plans. Even if all 1,337 of the doctors not currently participating in Healthchoice were to apply to join the panel, it is impossible to predict how many of those doctors would qualify and be accepted. And finally, it is impossible to estimate the effect on Plaintiff's practice. There is no way to know how many patients would choose Plaintiff as their internist or what services those patients would require. There is also no way to calculate the effect of adding new patients to Plaintiff's existing practice. Given the sheer number of patients he sees and the hours he works, it is not reasonable to assume *1185 that Plaintiff could absorb an unlimited number of new patients. Some displacement would inevitably take place. It appears that any damages Plaintiff may be able to claim are highly speculative. Therefore, Plaintiff is not an efficient enforcer of this alleged antitrust violation.

If, as his deposition testimony suggests, Plaintiff has brought this suit in order to force Defendants to accept him as a member of the Healthchoice closed panel PPO, he lacks standing because he cannot claim he has suffered an antitrust injury. He merely hopes to profit from the

allegedly anticompetitive conduct of others. If, as his affidavit testimony suggests, Plaintiff has brought this suit to force Healthchoice into operating as an open panel PPO, he lacks standing because he is not an efficient enforcer. Any damage that he might claim is entirely speculative. Since Plaintiff lacks standing, Defendants are entitled to summary judgment on the Sherman Act claims in Count I and Count II of Plaintiff's Complaint.

b. Market Definition and Market Power

Defendants have argued that Plaintiff cannot establish the elements of their claims. In part, the Defendants assert that Plaintiff is required to define the market and prove market power. Plaintiff asserts that the antitrust violation alleged is per se illegal. As set forth in Section II.b., a party need not prove market power if the antitrust violation is one of a limited group deemed to be illegal per se. In other cases, the plaintiff must establish market power as part of the rule of reason analysis.

Having reviewed the arguments and caselaw advanced by the parties, the Court finds the following guidance from the Supreme Court to be most instructive:

As we observed last Term ..., the

> category of restraints classed as group boycotts is not to be expanded indiscriminately, and the per se approach has generally been limited to cases in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor--a situation obviously not present here. Moreover, we have been slow to condemn rules adopted by professional associations as unreasonable per se, and, in general, to extend per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious.

FTC v. Indiana Fed'n of Dentists, 476 U.S. 447, 458-59, 106 S.Ct. 2009, 2017-18, (citations omitted) (emphasis added). Plaintiff has argued that CFMA and Healthchoice have fixed prices and that prices to consumers have increased. The data provided by Plaintiff suggests that costs for services for Healthchoice patients have gone up from 1990 to 1992. Brief in Opposition to Motions for Partial Summary Judgment (Dkt. 91), pp. 7-8. However, Plaintiff has provided no context for the data he recites. It is not clear whether these numbers indicate that costs

for services for Healthchoice patients have gone up more dramatically then other medical costs. Defendant has argued that HMOs and PPOs are well recognized programs for reducing medical costs. Plaintiff provides a recent article by two professors from the University of Connecticut suggesting that, over time, the price for HMOs may rise. Plaintiff's Appendix, Exhibit 15. This same article, however, recognizes that the growth of HMOs has, up to this point in time, been viewed as a procompetitive change in the health industry.

[11] In this suit, Plaintiff suggests that a closed panel PPO has an anticompetitive effect. This anticompetitive effect is far from obvious. If it were obvious, purchasers of health plans would avoid managed care benefit plans. Instead, statistics indicate purchasers are buying more managed care plans. Since the competitive effect is not immediately obvious, the Court would be unwilling to apply a per se approach in this case.

Plaintiff must, therefore, define the market and establish market power. Plaintiff has asserted that the relevant geographic market is the Orlando, Florida area and the relevant product market is

the provision of medical services by physicians and hospitals to patient members of Healthchoice. Complaint, para. 33. The Court feels compelled to note that Plaintiff's definition of product market is *1186 most peculiar. He has limited the product market to a service rendered solely by Defendants. If a plaintiff were permitted to use such an approach, it would in effect eliminate the requirement of establishing market power. Each and every defendant would have monopoly power in the sale of a distinctive product or service. A more reasonable product market would be the market for medical services in general or the market for medical services of an internist.

However, these observations are not essential to disposition of the pending motions. Since Plaintiff lacks standing to bring this federal antitrust claim, Defendants are entitled to summary judgment.

IV. Plaintiff's State Claims

In addition to Plaintiff's federal antitrust claims, Plaintiff has alleged violations of Florida's antitrust provisions. Specifically, Counts I and III assert a violation of Fla.Stat. s 542.18, and Count II asserts a violation

of Fla.Stat. s 542.19. Section 542.20, Fla.Stat. provides:

> Any activity or conduct exempt under Florida statutory or common law or exempt from the provisions of the antitrust laws of the United States is exempt from the provisions of this chapter.

Since the Court has concluded that Defendants are entitled to summary judgment on Plaintiff's federal antitrust claims, Defendants are similarly entitled to summary judgment on Plaintiff's state antitrust claims. Auton v. Dade City, 783 F.2d 1009, 1010 n. 1 (11th Cir.1986).

In Counts IV, V and VI, Plaintiff asserts various state law claims. Pursuant to 28 U.S.C. s 1367(c)(3), the Court declines to exercise supplemental jurisdiction over these claims. [FN9]

> FN9. The Court notes that Plaintiff's state court case, Case No. 93-1476, Ninth Judicial Circuit, Orange County, Florida, was stayed on April 21, 1993 and is still pending.

The Court recognizes that this case is being dismissed on the eve of trial and regrets that the parties have had to prepare for trial. To a certain extent,

the parties accept the risk of a delay in ruling when they stipulate to extend the deadline for filing dispositive motions. However, the delay in ruling on the pending motions was also due to Plaintiff's counsel's failure to cite to specific portions of the record. See, e.g., n. 3, 5 supra.

Accordingly, it is hereby ORDERED:

1. The Motion for Partial Summary Judgment by Defendant Central Florida Medical Affiliates, Inc. (Dkt. 46) is GRANTED.

2. The Motion for Summary Judgment by Defendants Orlando Regional Healthcare Systems, Inc. f/k/a Orlando Regional Medical Center and Sand Lake Hospital (Dkt. 58) is GRANTED.

3. The Motion for Partial Summary Judgment by Defendant Healthchoice, Inc. (Dkt. 60) is GRANTED.

4. Plaintiff's Motion to Strike the Supplemental Affidavit of Roger D. Blair (Dkt. 141) is DENIED.

5. Counts IV, V and VI of Plaintiff's Complaint are DISMISSED without prejudice.

6. The Clerk of the Court shall enter judgment against Plaintiff and in favor of Defendants on Counts I, II and III of Plaintiff's Complaint.

DONE AND ORDERED.

APPENDIX C – ORDER OF UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DENYING PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC FILED MARCH 18, 1996

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 94-3145

SCOTT D. LEVINE, M.D.,

Plaintiff-Appellant,

versus

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. f/k/a Orlando Regional Medical Center,

Defendants-Appellees.

On Appeal from the United States District Court for the Middle District of Florida

---

(Filed Mar. 18, 1996)

ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

(Opinion _____, 11th Cir., 19__, ___ F.2d ___).

Before: ANDERSON and CARNES, Circuit Judges, OWENS, U.S. District Judge, Middle District of Georgia

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Ed Carnes
UNITED STATES CIRCUIT JUDGE

ORD-42
(6/95)

APPENDIX D – JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, ORLANDO DIVISION FILED AUGUST 31, 1994

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF FLORIDA

SCOTT D. LEVINE, M.D.

V.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC., ET AL.

JUDGMENT IN A CIVIL CASE

CASE NUMBER: 93-153-CIV-ORL-22

[ ] **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] **Decision by Court.** This action came ~~Illegible~~ before the Court. The issues have been ~~Illegible~~ heard and a decision has been rendered, on the Defendants' motions for summary judgment.

IT IS ORDERED AND ADJUDGED

that judgment is entered in favor of the Defendants, Central Florida Medical Affiliates, Inc., Healthchoice, Inc., Sand Lake Hospital, and Orlando Regional Healthcare Systems, Inc., and against the Plaintiff, Scott D. Levine, M.D., on Counts I, II and III of the complaint.

August 31, 1994
Date

DAVID L. EDWARDS
Clerk

/s/ Mollie Anderson
Mollie Anderson
(By) Deputy Clerk

No. 95-2000

(2)

Supreme Court, U.S.
FILED
AUG 12 1996
CLERK

In The

Supreme Court of the United States

October Term, 1995

SCOTT D. LEVINE, M.D.,

Petitioner,

vs.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. f/k/a ORLANDO REGIONAL MEDICAL CENTER,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF IN OPPOSITION FOR RESPONDENT CENTRAL FLORIDA MEDICAL AFFILIATES, INC.

RONALD M. SCHIRTZER
Counsel of Record
ROBERT J. ENDERS
MARK J. WAXMAN
FOLEY & LARDNER
Attorneys for Respondent Central Florida Medical Affiliates, Inc.
111 North Orange Avenue
Suite 1800
P.O. Box 2193
Orlando, Florida 32802-2193
(407) 423-7656

9384
Lutz Appellate Services, Inc.
(800) 3 APPEAL • (800) 5 APPEAL • (800) BRIEF 21

32pp

LIST OF INTERESTED PARTIES

The Petitioner is Scott D. Levine, M.D., an individual. The Petitioner was the plaintiff in the district court, and the appellant before the Eleventh Circuit.

The caption of this case properly contains the name of all parties to this action. Respondent Central Florida Medical Affiliates, Inc. is a Florida corporation with no parent corporations or non-wholly owned subsidiaries. Central Florida Medical Affiliates, Inc. was a defendant in the district court, and an appellee before the Eleventh Circuit.

Respondent Health*choice* is a Florida for-profit corporation. It is a wholly owned subsidiary of Healthnet Services, Inc., a wholly owned for-profit subsidiary of Respondent Orlando Regional Healthcare System, Inc., f/k/a Orlando Regional Medical Center. Health*choice*, Inc. has no non-wholly owned subsidiaries. Health*choice*, Inc. was a defendant in the district court, and an appellee before the Eleventh Circuit.

Respondent Orlando Regional Healthcare System, Inc., f/k/a Orlando Regional Medical Center is a Florida non-profit corporation. Orlando Regional Healthcare System, Inc. has no parent corporation, and no non-wholly owned subsidiaries. Orlando Regional Healthcare System, Inc. was a defendant in the district court, and an appellee before the Eleventh Circuit.

Respondent Sand Lake Hospital is a licensed hospital in the State of Florida, which is owned by Orlando Regional Healthcare System, Inc. Sand Lake Hospital has no wholly owned subsidiaries. Sand Lake Hospital was a defendant in the district court, and an appellee before the Eleventh Circuit.

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PRELIMINARY STATEMENT

Petitioner Scott D. Levine,, M.D. seeks certiorari review of the decision of the Eleventh Circuit upholding the district court's award of summary judgment to the Respondents, including Central Florida Medical Affiliates, Inc. ("CFMA"). *Levine v. Central Florida Medical Affiliates, Inc.*, 72 F.3d 1538 (11th Cir. 1996). The Petitioner contends that it was error for the Eleventh Circuit to refuse to afford per se treatment to the Petitioner's claims under Section One of the Sherman Act, and that "confusion" exists regarding this Court's allegedly inconsistent prior rulings regarding the application of per se treatment for alleged antitrust violations.

Under Rule 10, Rules of the Supreme Court, review on writ of certiorari is not a matter of right, but of judicial discretion. Rule 10 specifically indicates that a petition for writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings, or the misapplication of a properly stated rule of law.

Recognizing the unlikelihood of a grant of certiorari review based upon an allegedly erroneous factual finding, the Petitioner alleges the Eleventh Circuit opinion conflicts with relevant decisions of this Court, and conflicts with decisions of other United States courts of appeal. To create the appearance of a question of law rather than a question of fact, in the questions presented in his petition, the Petitioner asks this Court to review the ruling of the Eleventh Circuit based on the premise that he has presented evidence of (1) a horizontal boycott of competitors which limits competition and consumer choice; and (2) a combination of competitors, through a professional association, that promotes and secures adherence to a fee schedule.

CFMA respectfully objects to Petitioner's statement of the

questions presented to this Court because, as evidenced in the opinions of both the district court and the Eleventh Circuit, the record below, treated in the light most favorable to the Petitioner, does not support the stated factual premises. The only "confusion" in this action comes from the Petitioner's false assumptions regarding the evidence presented to the district court and the Eleventh Circuit. Once that "confusion" is cleared up, it is readily apparent that the Eleventh Circuit properly followed a long and consistent line of legal precedent from this Court in denying the Petitioner's request for per se treatment of his antitrust claims, and upholding the district court's award of summary judgment to the Respondents.

In light of the erroneous premises in the questions presented by the Petitioner, CFMA offers the following restatement of the question to be presented to this Court for consideration of Petitioner's writ of certiorari:

1. Did the Eleventh Circuit, based upon the facts actually presented by the Petitioner to the district court, properly apply the appropriate legal standards of antitrust law in upholding the district court's grant of summary judgment to the Respondents?

In evaluating a case on summary judgment, where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial, and summary judgment is properly awarded to the non-moving party. *Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S. Ct. 1348, 1356, 89 L. Ed. 2d 538 (1986). As will be demonstrated below, both the district court and the Eleventh Circuit determined that the Petitioner failed to demonstrate collusive behavior by the Respondents that had any anticompetitive effect, and also failed to demonstrate any antitrust injury, despite ample opportunity to do so. The

purported error by the Eleventh Circuit is therefore not a failure to follow established principles of law, but rather alleged erroneous factual determinations based upon the record. Petitioner's request for certiorari review should accordingly be denied in accordance with the guidelines of Rule 10.

STATEMENT OF THE CASE

This case arises out of the denial of the Petitioner's request to participate in a preferred provider organization ("PPO") operated by Respondent Health*choice*, Inc. ("Health*choice*"). Like the majority of other PPOs and health maintenance organizations ("HMOs") in the Orlando area, Health*choice* utilizes a closed panel, which means that participation is not available to all qualified interested physicians or other providers. Closed panels permit PPOs to exercise greater control over physicians through utilization review, and customers of Health*choice* desire and often demand utilization of closed panels by PPOs and HMOs. [R3-80, ¶¶ 5-9; R3-81, ¶¶ 5-8; R3-76, ¶¶ 6 and 7.]

The record below indicates a dynamic and changing market for the purchase and sale of health care services. At the time summary judgment was granted to the Respondents by the District court, Health*choice* was one of thirty-eight (38) PPOs operating in the Orlando area. There were also eleven (11) HMOs and a vast array of traditional comprehensive insurance coverage companies ("TCICs") operating in the Orlando area as of the date summary judgment was granted. [R3-80, Exh. A.] PPOs, HMOs, and TCICs all compete against one another to provide comprehensive medical group coverage to employers, insurance companies, third party administrators, and government agencies (hereinafter collectively referred to as "Payors"). Individuals whose health care services are provided through Health*choice* represent less than a 6% share of the potential patients in the Orlando area. [R3-80, ¶ 18.]

Healthchoice, like other PPOs, enters into bilateral contracts with a limited number of healthcare providers, including physicians, hospitals, pharmacies, and durable medical equipment companies. Healthchoice then markets its panel of providers to interested Payors. Healthchoice negotiates with individual Payors the maximum allowable prices for services rendered or products furnished by panel members to enrollees of those Payors. After specific fees for a Payor are negotiated and agreed to by Healthchoice, panel members are given the option of providing services or products for no more than the negotiated price, or opting out of the panel for a particular Payor. [R4-110, Tab 40 at 100206-207.]

Healthchoice is a wholly owned for-profit subsidiary, two tiers removed, of Respondent Orlando Regional Healthcare Systems, Inc., f/k/a Orlando Regional Medical Center ("ORHS"). CFMA is a for-profit corporation owned and controlled by physicians who participate in Healthchoice. CFMA primarily acts as a physician advocacy group in non-price related matters such as the scope and nature of utilization review. [R3-80, ¶ 10.]

CFMA does not determine which physicians will be invited to participate in the Healthchoice panel. That decision is made by Healthchoice non-physician staff members. [R3-80, ¶ 10; *Levine*, 72 F.3d at 1547.] As noted by the Eleventh Circuit, CFMA members, including the four physicians who are on the board of directors of Healthchoice, are excluded from participating in the establishment of the maximum fee schedule used by Healthchoice, or the negotiation of prices for medical services between Healthchoice and employers, insurers, and other Payors. *Levine*, 72 F.3d at 1546. While participation in Healthchoice is a prerequisite for membership in CFMA, participating Healthchoice physicians do not have to be members of CFMA, and many are not. *Id.* at 1547.

As of the date summary judgment was granted by the District court, there were approximately 2,200 licensed physicians in the Orlando area, and more than 400 internists who participated in PPOs and HMOs, including the Petitioner, who is a panel member of two PPOs that compete with Health*choice*. The Health*choice* panel included 863 physicians and 80 internists as of the date summary judgment was granted. [R3-49, ¶ 15; R3-80, ¶ 16.] The denial of the Petitioner's request to participate in the Health*choice* panel had no adverse impact on his ability to compete in the Orlando area. In 1990, his first full year of practice after moving to the Orlando area in 1989, the Petitioner had a pre-tax net income of $553,176. In 1991, his pre-tax net income rose to $724,722, an increase of 31%. [R2-52, pg. 72.] In comparison, the average pre-tax net income of self-employed Florida internists in an American Medical Association study was $191,200 in 1992. [R2-49, ¶ 37.]

In addition to the improper premises discussed above, the Petitioner has made several misstatements of fact in his petition. The following three examples reflect erroneous statements of fact contained in the Petition:

1. In an effort to imply collusion, the Petitioner states that CFMA is privately owned by the same hospital which owns Health*choice*. [Pg. 22.] This is patently false. CFMA is owned by its physician members, as recognized by the Petitioner in his identification of the Parties to the Proceeding in his petition. [Pg. ii.]

2. In an effort to demonstrate anticompetitive effect and intent, the Petitioner states that CFMA doctors are prohibited from participating in any plan for a prospective Health*choice* Payor who has declined to do business with Health*choice*. [Pg. 5.] This is again false. Physicians are free to join other PPOs and HMOs, and most physicians on the Health*choice* panel are

members of several competing panels. [R2-49, ¶ 15; R3-80, ¶ 21.] The cited six (6) month restriction only applies to a former Health*choice* Payor that seeks to bypass utilization of Health*choice* by forming its own PPO provider panel. [R4-110, tab 32, 100026-27.]

3. In a further effort to demonstrate anticompetitive effect, the Petitioner contends that the fees paid to CFMA members were stable, uniform, and trending upward during a four-year period. [Pg. 21.] Yet, as noted by the Eleventh Circuit, there was no evidence presented by the Petitioner demonstrating that prices for services of Health*choice* physicians charged to Payors increased, and absolutely no evidence of how fees for Health*choice* physicians compare with those of non-Health*choice* physicians. *Levine*, 72 F.3d at 1553.

REASONS FOR DENYING THE WRIT

I.

THE PETITIONER FAILED TO ESTABLISH ANY FACTUAL BASIS FOR AN ALLEGED HORIZONTAL GROUP BOYCOTT FOR WHICH PER SE TREATMENT CAN BE AFFORDED UNDER THE ANTITRUST LAWS.

A. There Is No "Confusion" Regarding the Circumstances When the Per Se Rule Can Be Invoked.

The Petitioner alleges that it is necessary for this Court to clear up "confusion" regarding the treatment of horizontal group boycotts under the antitrust laws. Pg. 12. There is no confusion in the prior opinions of the this Court cited by the Petitioner, nor was the Eleventh Circuit "confused" in its refusal to grant per se treatment to the Petitioner's claims in this case.

This Court has clearly and unequivocally addressed the standards for application of per se treatment to alleged antitrust violations. Per se treatment is limited to those situations where:

> the challenged action falls into the category of agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use.

Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 289, 105 S. Ct. 2613, 86 L. Ed. 2d 202 (1985), (citing *Northern Pacific Railroad Co. v. United States*, 356 U.S. 1, 5, 78 S. Ct. 514, 2 L. Ed. 2d 545 (1958)).

Thus, before per se treatment is afforded, a plaintiff must demonstrate that the challenged activity is one that has a clear and apparent anticompetitive effect and no redeeming virtue. Demonstrating clear and apparent anticompetitive effect is not, as the Petitioner contends, a change of direction by this Court first evidenced in *Northwest Wholesale Stationers*. Preliminary review of the challenged activity to determine whether the per se or rule of reason approach should be applied in a particular case has been utilized by this Court since *Standard Oil Co. v. United States*, 221 U.S. 1, 31 S. Ct. 502, 55 L. Ed. 619 (1911).

The Petitioner has attempted to overcome the hurdles of demonstrating clear anticompetitive effect by invoking the mantra of "per se illegal group boycott," and citing to other cases in which this Court has afforded per se treatment to "group boycotts." In doing so, the Petitioner has ignored the prior

warnings of this Court against efforts to obtain per se treatment by pigeon-holing an activity into the broad category of "group boycott" without demonstrating that it is a naked restraint of trade with no purpose except stifling competition. *White Motor Co. v. United States*; 372 U.S. 253, 263, 83 S. Ct. 696, 702, 9 L. Ed. 2d 738 (1963); *Northwest Wholesale Stationers*, 472 U.S. at 298; *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 458, 106 S. Ct. 2009, 2018, 90 L. Ed. 2d 445 (1986).

B. The Petitioner Failed to Demonstrate Any Evidence of Requisite Horizontal Collusive Behavior Necessary to Establish a Group Boycott Claim Subject to the Per Se Illegal Rubric Under Section One of the Sherman Act.

The Petitioner failed to produce any evidence of a concerted refusal to deal involving agreement among the Petitioner's competitors. The evidence on record is undisputed that Health*choice*'s staff, not CFMA or the CFMA members of Health*choice*'s board of directors, make the decisions regarding which physicians will be invited to participate in Health*choice*'s panel. *Levine*, 72 F.3d at 1547.

Thus, despite Petitioner's claims to the contrary, the denial of participation in Health*choice* does not fall into the category of horizontal group boycotts deemed per se illegal by this Court in *Associated Press v. United States*, 326 U.S. 1, 65 S. Ct 1416, 89 L. Ed. 2013 (1944), *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 79 S. Ct. 705, 3 L. Ed. 2d 741 (1959), *United States v. General Motors Corp.*, 384 U.S. 127, 86 S. Ct. 1321, 16 L. Ed. 2d 415 (1966), and *F.T.C. v. Superior Court Trial Lawyers Assn.*, 493 U.S. 411, 110 S. Ct. 768, 107 L. Ed. 2d 851 (1990). Neither does the Eleventh Circuit's decision represent a deviation from the standard analysis utilized by courts to review antitrust claims. In each of the cases cited above, this Court determined whether the plaintiffs were able to demonstrate collusive activity

that had a clear and apparent anticompetitive effect before affording per se treatment.

In *Associated Press*, the plaintiff demonstrated that Associated Press was the largest news agency in the United States, and that exclusion from membership in the organization placed the plaintiff at a significant competitive disadvantage. 326 U.S. at 17-18. The Associated Press bylaws, established and controlled by existing Associated Press members, placed restrictions on new members who competed with existing members (including payment of significant fees and other onerous conditions) that were not imposed on new members who did not compete with existing members. Because of the clear impact on competition, and obvious anticompetitive and discriminatory treatment of new members who competed with existing members, this Court determined that the adoption and enforcement of the bylaws by Associated Press members constituted collusive behavior that was a per se antitrust violation. *Id.* at 18-19.

In *Klor's, Inc.*, the plaintiff was able to demonstrate that one of its direct competitors convinced various manufacturers and distributors of electrical appliances to refuse to sell products to the plaintiff, or to only sell products at discriminatory prices with highly unfavorable terms. These agreements seriously handicapped the plaintiff's ability to compete, and resulted in significant loss of profits, goodwill, reputation, and prestige for the plaintiff. 359 U.S. at 208. Although the plaintiff was not able to demonstrate that his exclusion from the market would cause a significant impact on the availability of products to consumers, this Court was persuaded that the plaintiff had demonstrated a clear and apparent anticompetitive effect with no redeeming virtue. Applying a per se analysis, this Court held that the boycott of the plaintiff by many of the major manufacturers and distributors in the affected industry violated the antitrust laws. *Id.* at 213.

In *United States v. General Motors Corp.*, the challenged activity was a mandate imposed by General Motors (as the result of complaints by several competing General Motors dealers) precluding dealers from selling cars to discount houses. The United States demonstrated that the participation of General Motors, which controlled the supply of cars to the dealers, combined with the vigilant enforcement efforts of competing dealers, effectively ended the practice of selling cars to discount houses for resale to consumers in the Los Angeles area. 384 U.S. at 135-138. This Court held that the government had demonstrated the requisite collusive activity and clear anticompetitive effect required for per se treatment of a Section One Sherman Act claim. *Id.* at 145.

In *Superior Court Trial Lawyers Association*, the F.T.C. was able to demonstrate that members of the defendant association had collusively agreed not to take on additional court-appointed cases unless the government increased the fees for court appointed attorneys. The Association's efforts proved successful, as the system essentially shut down when the boycott went into effect, and the government was persuaded to increase the fees. 493 U.S. at 417-418. Having demonstrated the clear anticompetitive effect of the collusive group effort, this Court held that there was no special exemption from per se treatment where the intended efforts of the defendants were to provoke legislative action. This Court therefore utilized a per se analysis in ruling that the boycott was a violation of the antitrust laws. *Id.* at 430-31.

Unlike the circumstances in *Superior Court Trial Lawyers Association*, the Petitioner's case is not one in which the victim of the boycott is a buyer of the allegedly colluding defendants. Instead, the Petitioner's only plausible horizontal claim in this case is premised on an alleged conspiracy involving agreement among CFMA members to "boycott" not a buyer from or seller to those competitors, but simply another competitor, the Petitioner.

Nor is the Petitioner's case similar to the circumstances in *FTC v. Indiana Federation of Dentists*. In that case, the alleged horizontal boycott involved an agreement among competing dentists to withhold patient x-rays from insurance companies that requested them in reviewing dentists' services for reimbursement. 476 U.S. at 451. Thus, once again, the intended victims of the horizontal boycott were the customers of the conspirators, not a fellow competitor.[1]

In *Associated Press, Klor's Inc.*, and *United States v. General Motors*, this Court applied the per se approach where the alleged collusive action by competitors was to disadvantage one or more of their direct competitors, either by directly denying, or persuading or coercing suppliers or customers to deny, relationships the competitors needed in the competitive struggle. *See also, Northwest Wholesale Stationers*, 472 U.S. at 294. But the Petitioner in this case has produced no evidence of any such coercion by CFMA or its members, or the denial of relationships necessary for the Petitioner to compete for patients in the Orlando area. Thus, the holdings of *Associated Press, Klor's Inc.* and *United States v. General Motors* are inapposite to the Petitioner's case.[2]

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1. It is interesting to note that the Court in *F.T.C. v. Indiana Federation of Dentists* applied a rule of reason rather than a per se analysis to the group boycott claims, despite the uncontested fact that a large group of competing dentists conspired with one another to withhold x-rays from insurance companies seeking to determine appropriate levels of reimbursement for dental services. *Id.* 458-59. The Court did, however, rule that the F.T.C. was not required to conduct a detailed market analysis to support its antitrust claims under the rule of reason analysis because significant anticompetitive effect had been established, and no compelling procompetitive justification for the boycott had been offered by the defendants. *Id.* 460-61; 463-64.

2. Similarly, despite the Petitioner's claims to the contrary, there is no conflict among the circuit courts in the invocation of the per se rule. In *Denny's*

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C. Petitioner Failed to Demonstrate a Clear Anticompetitive Effect With No Redeeming Virtue — A Prerequisite for Invocation of the Per Se Rule.

As the Eleventh Circuit noted, Dr. Levine failed to demonstrate that Health*choice* and CFMA have the requisite market power that would allow them to deny relationships necessary for the Petitioner to compete in the Orlando area. *Levine*, 72 F.3d at 1550. Health*choice* patients are free to use non-Health*choice* physicians, limited only by higher deductible payments established by the Payors, not by Health*choice* or CFMA and its members. *Id.* at 1547. Health*choice* patients are also provided with options regarding their health plans, and are

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(Cont'd)

Marina, Inc. v. Renfro Productions, Inc., 8 F.3d 1217 (7th Cir. 1993), the plaintiff demonstrated that because of his price cutting efforts, his competitors colluded with the operators of the major boat shows in Indiana to exclude the plaintiff from participating, significantly impacting the plaintiff's ability to compete. *Id.* at 1219-1220. Although the Court elected not to perform a "quick look" into the potential effect of the restraint on the relevant market, it based its decision to afford per se treatment to the plaintiff's claims on the undisputed fact that the boycott was a retaliatory effort by other boat dealers against a price cutting competitor, and no procompetitive justification was offered by the defendants to explain their behavior.

The Petitioner also cites to *Alvord-Polk, Inc. v. F. Schumacher & Co.*, 37 F.3d 996 (3d Cir. 1994), as an alleged use of per se treatment for a group boycott case. The only reference to per se treatment in that case, however, is a discussion of the availability of per se treatment for Section One violations, and the lack of per se treatment for Section Two cases. *Id.* at 1000. Nowhere in the opinion (which reversed an award of summary judgment to the defendants based upon a determination that a sufficient factual question of collusive behavior existed) does the Third Circuit require that the alleged conspiracy by retail wallpaper stores and wallpaper manufacturers against discount wallpaper dealers be afforded per se treatment upon remand.

free to switch to other plans if they are dissatisfied with the Health*choice* program. *Id.* at 1552-53. Thus, even if the Petitioner had presented any evidence of an agreement between Health*choice* and CFMA members to exclude the Petitioner from the Health*choice* panel, that agreement would most properly have been analyzed under a rule of reason approach due to the lack of apparent anticompetitive effect.

The Respondents also demonstrated significant "redeeming virtue" associated with closed-panel PPOs and HMOs. Managed care organizations, which are relatively new to the healthcare market, have overtaken traditional comprehensive insurance coverage as the health care plan of choice. Such organizations accounted for 69% of potential patients in the Orlando area at the time summary judgment was awarded by the District court. [R3-80, ¶18; R6-147. pg. 17.] There also is vigorous competition in the Orlando area for comprehensive healthcare coverage, with no one organization covering more than 7.5% of the population. [R3-80, ¶18.] The procompetitive benefits of PPOs have been widely acknowledged. [R3-49, ¶¶7, 10.] Further, as the Eleventh Circuit noted, the Department of Justice ("DOJ") enforcement policy has recognized that selective contracting by PPOs and providers may be a method by which the PPOs achieve quality and cost containment goals that enhance their ability to compete in the market. DOJ Enforcement Policy at 42.[3]

The Petitioner has conspicuously failed to identify a single instance in which the exclusion of a physician from panel participation in a managed care organization was analyzed under the per se approach. In fact, every antitrust case involving membership in a managed care organization that the undersigned

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3. The DOJ therefore requires a rule of reason rather than a per se analysis of potential antitrust violations. DOJ Enforcement Policy at 42. Additionally, the State of Florida has authorized the utilization of closed panels by PPOs. Section 627.6471, Fla. Stat.

counsel was able to find was analyzed under the rule of reason approach. *Doctors Hospital of Jefferson, Inc. v. Southeast Medical Alliance, Inc.*, 897 F. Supp. 290 (E.D. La. 1995); *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*, 791 F. Supp. 956 (N.D.N.Y. 1992), *aff'd*, 996 F.2d 537 (2d Cir. 1992), *cert. denied*, 510 U.S. 947, 114 S. Ct. 388, 125 L. Ed. 2d 337 (1993); *Williamson v. Sacred Heart Hospital of Pensacola*, 1993 WL 543002 (N.D. Fla. 1993), *aff'd*, 41 F.3d 667 (1994), *cert. denied*, __ U.S. __, 115 S. Ct. 2556, 132 L. Ed. 2d 810 (1995); *Hassan v. Independent Practice Associates, Inc.*, 698 F. Supp. 679 (E.D. Mich. 1988); *Northwest Medical Laboratories, Inc. v. Blue Cross Blue Shield of Oregon*, 775 P.2d 863 (Or. Ct. App. 1989), *aff'd*, 794 P.2d 428 (Or. 1990).

Further support for a rule of reason approach in the context of physician "privileges" is found in this Court's opinion in *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 104 S. Ct. 1551, 80 L. Ed. 2d 2 (1984). In that case, this Court refused to utilize a per se analysis in evaluating the antitrust claims of a physician who was denied staff privileges at a hospital. *Id.* at 15-16. Yet, denial of access to a hospital with a 30% market share (*Id.* at 426) has far more potential for anticompetitive effects than denial of a single competitor's application for membership in a PPO with less than 6% of the available patients in the Orlando area.

The record below indicates that the Petitioner failed to establish that Health*choice*'s utilization of a closed panel had any apparent anticompetitive effect on the market for medical services with no redeeming value. Based upon that record, the Eleventh Circuit properly followed established precedent in rejecting the Petitioner's assertion that the Respondents' alleged "group boycott" activities should be evaluated under the per se approach. There was accordingly no error in the Eleventh Circuit's treatment of antitrust precedent, nor its ruling.

D. Summary Judgment Was Properly Awarded to the Respondents With Regard to Petitioner's Group Boycott Claims.

Under the guidelines established by this Court in *Matsushita*, the Petitioner could not withstand the Respondents' motions for summary judgment merely by alleging the existence of a horizontal group boycott. He was required to present some evidence that CFMA or its members controlled the decision by Health*choice* to utilize a closed panel, or that the utilization of a closed panel had a clear and apparent anticompetitive effect. This is especially true in light of the numerous procompetitive reasons for utilization of a closed panel offered by the Respondents in their motions for summary judgment. 475 U.S. at 588.

Viewing the evidence, facts, and inferences in the light most favorable to the Petitioner, both the District court and the Eleventh Circuit determined that he failed to establish an alleged horizontal group boycott with a clear and apparent anticompetitive effect that would require per se treatment under the antitrust laws. Having failed to meet his burden in the District court, the Petitioner's request for certiorari should be denied.

II.

THE PETITIONER FAILED TO PROVIDE ANY EVIDENCE OF AN AGREEMENT TO FIX PRICES.

A. The Petitioner Failed to Present Evidence of Collusive Behavior Necessary to Establish a Price-Fixing Conspiracy Under Section One of the Sherman Act.

The Petitioner asserts that the utilization of a Master Payor Rate Schedule constitutes an illegal conspiracy to fix prices for

which per se treatment is mandated. Through his phrasing of the question presented to this Court, the Petitioner seems to imply that there was some question in the Eleventh Circuit's analysis of his claim as to whether the claim should be analyzed under a rule of reason or per se approach. This was not, in fact, an issue addressed by the Eleventh Circuit. The basis for the Eleventh Circuit's decision to uphold the award of summary judgment to the Respondents on the price-fixing claim was clearly and succinctly stated:

> Because there is no genuine issue of material fact regarding the existence of an agreement among Health*choice*, CFMA, or its member doctors to fix provider fees, and because defendants are entitled to judgment as a matter of law, Dr. Levine's section 1 claim against these defendants, to the extent that it alleges illegal price fixing, fails.

Levine, 72 F.3d at 1548.

In addition to his confusing references to per se treatment, the Petitioner misleads this Court by substituting CFMA for Health*choice* when discussing the establishment and negotiation of fees with Health*choice* Payors. The record is, however, devoid of any evidence supporting the Petitioner's contention that CFMA or any of its members have any involvement in establishing the Master Payor Rate Schedule, or negotiating the maximum prices that individual Payors will pay for physician services. As noted by the Eleventh Circuit:

> Although Dr. Levine did not specifically argue to this Court that the Defendants illegally fixed prices, *i.e.* provider fees, there are portions of his brief where he appears to

> assume the existence of such an agreement. That assumption is contrary to the uncontroverted evidence in the record, which establishes that there was no agreement between Health*choice*, CFMA, and their member physicians to fix provider fees. Health*choice* negotiates the provider reimbursement schedule directly with the payors, not with providers. Health*choice* does not consult any physician providers when it compiles the CPT code unit values or the Master Payor Rate Schedule, and physician members of the Health*choice* board of directors are excluded from the reimbursement schedule proposal and approval process. Providers must either accept not more than the maximum reimbursement negotiated by Health*choice* with the payors and not charge the patient for any difference between their fee and the reimbursement, or else opt out.

Levine, 72 F.3d at 1548.

The Petitioner relies heavily on this Court's decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 102 S. Ct. 2466, 73 L. Ed. 2d 48 (1982), in support of his contention that the Eleventh Circuit erred in upholding summary judgment on the Petitioner's price-fixing claims. The Petitioner, however, ignores a significant distinction between the facts presented to this Court in *Maricopa County Medical Society* and the facts presented to the District and Circuit courts in this case.

In *Maricopa County Medical Society*, the evidence clearly established that the medical society which established the

maximum fee schedule was controlled by its physician members, and that the maximum fee schedule was established by majority vote of the physicians. 457 U.S. at 340-341. This contrasts significantly with the facts in this case. Here, it is undisputed that Health*choice* establishes the maximum allowable fee schedule and negotiates the provider reimbursement schedule directly with individual Payors. Fees are established and negotiated without any involvement of or participation from CFMA, including the CFMA members on the Health*choice* board of directors. *Levine*, 72 F.3d at 1548.

This Court indicated in footnote 26 in *Maricopa County Medical Society* that it was not condemning arrangements in which physicians, through bilateral contracts, agreed to a maximum fee schedule set by someone other than the physicians. 457 U.S. at 352. It further noted that the United States, in an amicus curiae brief, believed that such arrangement in which the maximum fees were set by an insurer would be legal, absent evidence of a conspiracy by the providers. *Id.* Shortly thereafter, analogous situations were addressed in two Circuit court cases. Both Circuit courts found that no antitrust violation had occurred, and this Court denied petitions for certiorari in both instances. *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016, 105 S. Ct. 2021, 85 L. Ed. 2d 303 (1985); *Kartell v. Blue Shield*, 749 F.2d 922, 923-26 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029, 105 S. Ct. 2040, 85 L. Ed. 2d 322 (1985).

The facts of *Pennsylvania Dental Association* are strikingly similar to those in this case. The defendant, Blue Shield, entered into bilateral contracts with dentists that required the dentists to accept the maximum fee determined by Blue Shield as payment in full for services provided to patients covered by Blue Shield plans. 745 F.2d at 253. Like Health*choice*, one-half of the board

of directors of Blue Shield was comprised of physicians and dentists who provided services to Blue Shield customers. *Id.* However, unlike Health*choice*, Blue Shield did not exclude its physician and dentist board members from participation in the establishment of fees to be paid to physicians and dentists. *Id.* at 253-254.

Despite the involvement of physician and dentist board members in pricing decisions, the Third Circuit found no price-fixing conspiracy among the defendants due to the lack of any evidence that the dentists or physicians controlled the pricing policies of Blue Shield. The Third Circuit reasoned that in the absence of any evidence of collusive behavior among dentists that affected Blue Shield's payments, there could be no Section One violation. Blue Shield was therefore not precluded by the antitrust laws from establishing a maximum fee policy, or from having physicians and dentists agree in advance to abide by that policy. *Id.* at 256.

The Third Circuit noted that under the controlling precedent of *Maricopa County Medical Society*, if the plaintiffs had established that the pricing structure utilized by Blue Shield was controlled by the competing physicians and dentists, the maximum fee structure could be considered a price-fixing conspiracy. *Id.* at 257. Other Circuit courts had found potential antitrust violations where control by competing physicians had been established. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of Michigan*, 740 F.2d 423 (6th Cir. 1984).

Despite ample opportunity through discovery to establish any evidence of physician control over pricing policies, the plaintiffs in *Pennsylvania Dental Association* were unable to present any such evidence. *Id.* at 257. Similarly, the Petitioner in

this action, despite receiving an extension of time from the District court to complete discovery and supplement his response to the Respondents' summary judgment motions [R3-92; R4-117], was unable to provide any evidence that CFMA or its physician members had any control over the maximum fees for physician services established by Health*choice* and the individual payors.

In *Kartell*, the First Circuit, in an opinion by Justice Breyer, used reasoning similar to that of the Third Circuit in *Pennsylvania Dental Association* in rejecting a price-fixing challenge to a maximum fee structure. The defendant, Blue Shield, required physicians seeking reimbursement for services provided to Blue Shield enrollees to execute contracts which required acceptance of Blue Shield's "usual and customary charge" as payment in full. With no evidence of control of the fee schedule by the participating physicians, the First Circuit held that the bilateral contracts between Blue Shield and numerous competing physicians did not amount to collusive behavior necessary to establish a price-fixing claim, despite the fact that the bilateral contracts tended to make fees paid to the competing physicians uniform. *Kartell*, 749 F.2d at 925.

Proof of collusive behavior is essential to any Section One claim. *Copperweld Corp. v. Independent Tube Corp.*, 467 U.S. 752, 767-69, 104 S. Ct. 2731, 2739-41, 81 L. Ed. 2d 628 (1984). A conspiracy, combination, or agreement in violation of the antitrust laws cannot be inferred unless the Petitioner presents evidence that tends to exclude the possibility of independent action by the alleged conspirators. *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 768, 104 S. Ct. 1464, 79 L. Ed. 2d 775 (1984). Execution of bilateral contracts between Health*choice* and CFMA members, under which CFMA members agreed to accept the maximum fees negotiated between

Health*choice* and Payors as payment in full for service rendered to Health*choice* patients, without any evidence that CFMA members controlled Health*choice*, or colluded among themselves to fix prices, cannot be the basis for inferring collusive behavior necessary for a price-fixing claim. The Eleventh Circuit therefore properly upheld the grant of summary judgment to the Respondents.

B. The Petitioner Lacks Standing to Pursue a Section One Price-Fixing Claim Against the Respondents.

In upholding the grant of summary judgment to the Respondents on the Petitioner's Section One price-fixing claim based upon the absence of evidence of collusion, the Eleventh Circuit consciously elected not to address the issue of the Petitioner's standing to pursue this claim. *Levine*, 72 F.3d at 1545. Assuming, arguendo, that the Petitioner had been able to offer any evidence of collusive behavior of participating physicians in establishing the maximum fees to be charged by Health*choice* providers, the District court's grant of summary judgment to the Respondents was still proper due to Petitioner's lack of standing to pursue his antitrust claims. CFMA's successful challenge to the Petitioner's standing to pursue his antitrust claims is not, as the Petitioner suggests, meritless, nor has CFMA abandoned its challenge.

To establish standing to pursue an antitrust claim, the Petitioner was required to demonstrate each of the following requirements: (1) that he suffered some injury as a result of the alleged anticompetitive action; (2) that his alleged injuries coincide with the public detriment tending to result from the alleged anticompetitive action; and (3) that he is an efficient enforcer of the antitrust laws. *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 537, 542, 103 S. Ct. 897, 908, 910-11, 74 L. Ed. 2d 723

(1983); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489, 97 S. Ct. 690, 697, 50 L. Ed. 2d. 701 (1970); *Cargill Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 111, 107 S. Ct. 484, 490, 93 L. Ed. 2d 427 (1986). The Petitioner has failed to provide any evidence demonstrating that he can meet any of the three requirements.

The undisputed evidence on record establishes that the Petitioner's practice has expanded and prospered, despite the alleged existence of a price-fixing conspiracy among CFMA members and others. *Levine*, 72 F.3d at 1551. As the Eleventh Circuit noted, the Petitioner failed to produce any evidence that the Petitioner lost a single patient as a result of the alleged conspiracy to limit the Petitioner's access to patients or control prices in the Orlando market for healthcare services. *Id.* at 1552-53. Further, there is nothing in the record that indicates that the Petitioner was prevented from directly contracting with Payors to provide services to their enrollees at any price to which the Petitioner and the Payors could agree. Thus, as the district court found in granting summary judgment to the Respondents, Petitioner suffered no perceivable injury as a result of the alleged anticompetitive activities.

The district court also found that the Petitioner did not suffer injuries that coincide with the public detriment tending to result from the alleged anticompetitive actions of the Respondents. [R6-147, pp. 15-16.] As the Eleventh Circuit noted, no evidence was presented demonstrating that the maximum fee schedule established by Health*choice* artificially inflated the fees of Health*choice* providers over non-Health*choice* providers. *Levine*, 72 F.3d at 1552. Indeed, the Petitioner presented no evidence that prices charged to Payors for services of Health*choice* panel members had any effect on prices outside of the Health*choice* network.

Even if, contrary to the record, higher provider prices to Health*choice* Payors had resulted from the Respondents' actions, the Petitioner still would have suffered no injury. Any higher in-network prices would increase the Petitioner's ability to compete for Health*choice* enrollees, by reducing the impact to Petitioner of waiving deductible and co-payment requirement imposed on Health*choice* enrollees by the Payors. Further, if any impact to non-Health*choice* prices had been established, the likely impact from higher prices for Health*choice* physicians would be higher prices to non-Health*choice* patients. This would again fail to create any injury to the Plaintiff, as he would suffer no damage from higher prevailing prices for physician services.

As this Court discussed in *Maricopa County Medical Society*, a possible adverse effect of a maximum fee schedule that artificially lowers prices is the tendency to drive down prices outside the network, and to limit innovative but more costly methods of providing services. 457 U.S. at 347. The Petitioner, however, presented no evidence that the maximum fee schedule utilized by Health*choice* artificially deflated the prices he was able to charge his patients, or in any way interfered with the manner in which he treated patients. Thus, he has demonstrated no "antitrust injury" associated with the alleged price-fixing scheme.

As the district court noted, if the Petitioner had been able to demonstrate any injury resulting from the alleged price-fixing scheme, he still would not be an efficient enforcer of the antitrust laws. [R6-49, pg. 16.] The Petitioner is a single practitioner who, while alleging that Health*choice* and CFMA were engaging in an illegal price-fixing scheme, also seeks to join Health*choice* and CFMA so that he can obtain access to Health*choice* patients. The only "injury" that would be redressed by permitting the Petitioner to join the Health*choice* panel is potential loss of market share or foregone extra profits. Injury to a single

competitor, rather than to competition, is not the kind of injury the antitrust laws were intended to forestall. *Brunswick Corp.*, 429 U.S. at 487-88. This is especially true in the present case, where the Petitioner is already earning substantially more than the average internist in the Orlando area. *Levine*, 72 F.3d at 1551.

CONCLUSION

As noted above, the Eleventh Circuit followed controlling precedent in its analysis of the Petitioner's claims, and found no antitrust violation due to the absence of any record evidence demonstrating collusive behavior among competitors, anticompetitive effect in any market, or antitrust injury suffered by the Petitioner. The Supreme Court and circuit court cases cited by the Petitioner in his request for "GVR" treatment of the Eleventh Circuit opinion, many of which were not cited by the Petitioner in his briefs to the district court or the Eleventh Circuit, are not inconsistent with the Eleventh Circuit opinion. In each of those cases, the plaintiffs presented evidence of anticompetitive activity leading to anticompetitive effects — a necessity to withstand a motion for summary judgment. Put plainly and simply, this Petitioner has not, despite ample opportunity to do so.

Thus, even if this Court desires to consider the antitrust implications of maximum fee schedules and closed panels in the managed healthcare field, Petitioner's case, in which there was no demonstration of injury to the competitor plaintiff, let alone competition, is a poor choice for such eview. This Court should accordingly deny the Petitioner's request for certiorari review.

Respectfully submitted,

RONALD M. SCHIRTZER
Counsel of Record
ROBERT J. ENDERS
MARK J. WAXMAN
FOLEY & LARDNER
Attorneys for Respondent
Central Florida Medical Affiliates, Inc.
111 North Orange Avenue
Suite 1800
P.O. Box 2193
Orlando, Florida 32802-2193
(407) 423-7656

(4)

Supreme Court, U.S.
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No. 95-2000

In The

Supreme Court of the United States

October Term, 1995

SCOTT D. LEVINE, M.D.,

Petitioner,

vs.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC., f/k/a ORLANDO REGIONAL MEDICAL CENTER,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF OF RESPONDENTS HEALTHCHOICE, INC. AND ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

DAVID L. EVANS
(Counsel of Record)
THOMAS R. HARBERT
MATEER & HARBERT, P.A.
Post Office Box 2854
Orlando, Florida 32802
407/425-9044
407/423-2016 (Fax)
Attorneys for Respondents, Orlando Regional Healthcare System, Inc., and Healthchoice, Inc.

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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LIST OF PARENT COMPANIES AND NONWHOLLY OWNED SUBSIDIARIES

Pursuant to Supreme Court Rule 29(6), the following constitutes a list of all parent companies and nonwholly owned subsidiaries of Orlando Regional Healthcare System, Inc. and Healthchoice, Inc.:

1. Healthnet Services, Inc. is the parent company of Healthchoice, Inc. and a wholly-owned subsidiary of Orlando Regional Healthcare System, Inc. ("ORHS").

2. ORHS is a 50% owner of M.D. Anderson Cancer Center of Orlando, Inc.

3. ORHS is a 50% owner of South Lake Hospital, Inc.

4. ORHS is a limited partner in Orlando Institute for Cardiac Care, Ltd., d/b/a Outpatient Cardiovascular Center of Orlando.

5. ORHS has numerous other wholly owned subsidiaries.

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STATUTE

15 U.S.C. § 1 10

I.

STATEMENT OF THE CASE

This is a case about one highly successful physician, Petitioner Scott D. Levine, who was denied membership in one managed health care plan with a market share of less than 6%, and whose medical staff privileges were temporarily suspended by a non-profit hospital system with 29% of the hospital beds in the Orlando, Florida area. It is a case in which the plaintiff physician was highly successful prior to the events giving rise to this litigation, and even more successful following the actions alleged by the plaintiff physician to constitute antitrust violations. It is not a case about injury to competition. It is not a case brought by the government to challenge the validity of a managed care plan, nor is it a challenge to a managed care plan by a purchaser of managed care. It is an attempt by a single competitor to create a federal antitrust suit for the purposes of recovering treble damages. The U.S. District Court for the Middle District of Florida, and the Eleventh Circuit Court of Appeals, in a well reasoned opinion, both soundly rejected the Petitioner's antitrust claims. For the reasons set forth below, these Respondents respectfully submit that the Petitioner's Petition for Writ of Certiorari should be denied.

Orlando Regional Healthcare System, Inc. f/k/a Orlando Regional Medical Center ("ORHS") is a not for profit corporation which operates a hospital network in the metropolitan Orlando area. Healthchoice, Inc. ("Healthchoice") operates a preferred provider organization ("PPO") in the same area and is owned by Healthnet Services, Inc., a wholly owned for-profit subsidiary of

ORHS. Dr. Levine filed the antitrust claims in question against ORHS, Sand Lake Hospital (a division of ORHS), Healthchoice, and Central Florida Medical Affiliates, Inc. ("CFMA").

Part of Petitioner's claim relates to an administrative decision made by Healthchoice staff to deny Dr Levine's request for membership in the Healthchoice Preferred Provider Organization. The decision was made based on the fact that there were already an adequate number of internal medicine physicians practicing in Dr. Levine's geographical area. Later, in an unrelated action, Dr. Levine's medical staff privileges were temporarily suspended by ORHS because of concerns regarding the quality of his patient care. Dr. Levine also asserted an antitrust claim against ORHS relating to that temporary suspension.

Following the grant of summary judgment in favor of Respondents on Petitioner's antitrust claims, Petitioner appealed to the Eleventh Circuit Court of Appeals. The Eleventh Circuit affirmed the District Court's order granting summary judgment (see *Levine v. Central Florida Medical Affiliates, Inc. et al.*, 72 F.3d 1538 (11th Cir. 1996)) and Petitioner seeks review of that Order.

Dr. Levine, in his Statement of the Case, omitted several relevant facts from his Petition. Specifically, the following uncontroverted facts were presented to the U.S. District Court and the Eleventh Circuit Court of Appeals:

1. Dr. Levine has enjoyed great financial success in the practice of medicine. Dr. Levine's pre-tax net earnings from the practice of

medicine from 1990 through 1992 is summarized in the following table:

1990	$553,176.00
1991	$724,722.00
1992	$692,079.00

In the year during which Dr. Levine alleges that he was the victim of an antitrust conspiracy (1991), he actually increased his income by thirty-one percent ($171,546.00) over the preceding year. (R2-53-466-485). According to the Center for Health Policy Research of the American Medical Association, the average pre-tax net earnings for self-employed Florida internists in 1991 was $191,200.00, and the 75th percentile pre-tax net earnings for Florida internists in 1991 was $240,000.00. (R2-49-¶ 37).

2. During the relevant time period, Dr. Levine was one of approximately 2,200 licensed physicians practicing in the Orlando Area. Records of managed care plans in the Orlando Area indicated that over 400 Orlando Area internists participate in managed care plans. (R2-49-¶ 15; R3-80-¶ 16). At the time that Dr. Levine's privileges were temporarily suspended by ORHS in 1991 there were 163 members of the Department of Medicine at ORHS, and there were 236 such members as of 1994. (R3-65-¶ 2).

3. The market for health care insurance in the Orlando Area is highly competitive. In 1994, there were at least 38 PPOs and 11 Health Maintenance Organizations ("HMOs") operating in the Orlando Area, and a vast array

of traditional comprehensive insurance coverage ("TCIC") companies. (R3-80, Exh.A.) TCIC's pay health care providers on a fee-for-service basis. Payors in PPOs and in some HMOs also pay providers on a fee-for-service basis. However, such fees are negotiated in advance, at a discounted rate. Providers are compensated for their discounted rate because the PPO and/or HMO provides them with an increased patient base. HMOs generally restrict their enrollees solely to use of Network providers. PPOs do not prohibit enrollees from utilizing non-Network providers; however, economic incentives are usually provided to the enrollee if Network providers are used. (R3-80-¶ 4.)

4. Market studies prepared by Healthchoice indicated that of an Orlando Area population of approximately 1,137,000, 69% were covered under HMO or PPO plans, with the remainder having TCIC or no coverage at all. No single PPO or HMO covered more than 7.5% of the population. In 1994, Healthchoice had approximately 68,000 enrollees, representing less than 6% of the Orlando health care market.

5. At the time in question, Healthchoice had 863 physicians in its Network in Orange, Seminole, and Osceola Counties, eighty (80) of whom indicated their specialty area as internal medicine, the area in which Dr. Levine practices. There were approximately 2,200 licensed physicians in the Orlando Area, and over 400 internists in the Orlando Area participate in managed care plans. (R3-49-¶ 15; R3-80-¶ 16.) There were twenty-one (21) hospitals in the

Orlando Area, nine (9) of which were in the Healthchoice Network. Four (4) of those hospitals had no affiliation with ORHS, including Health Central and Winter Park Hospital, two of ORHS's significant competitors. (R3-80-¶ 22.)

6. CFMA is a for-profit corporation. It is not necessary to be a member of CFMA to be a participating physician in the Healthchoice Network, and numerous physician members of Healthchoice are not members of CFMA. CFMA primarily acts as a physician advocacy group. (R3-80-¶ 10.) Initially, CFMA was responsible for credentialing physicians for membership in Healthchoice; i.e. determining their competency as physicians. This is a separate and distinct issue from determining the need for additional physicians in the Network. Healthchoice was always responsible for determining the need for additional physicians in the Network. Since 1991, Healthchoice has also taken over responsibility for credentialing decisions. (R3-80-¶ 10.)

7. The hospital services market in the Orlando Area, defined as Orange, Seminole, and Osceola Counties, has approximately 4,446 licensed hospital beds. The hospital market in the Orlando Area has three major competitors, ORHS, Florida Hospital, and Columbia Park Healthcare, along with a number of smaller hospitals. At all times relevant to this action, the largest of these competitors was Florida Hospital, which had 33% of the licensed beds in the Orlando Area. ORHS had 29% of the licensed beds. (R2-49-¶ 20 Exh. "I"; R3-68-¶ 3).

8. Dr. Levine's ability to compete in the internal medicine market in Orlando was never affected by any of the Respondents' actions in this matter. He held medical staff privileges at Florida Hospital's several campuses, Health Central, Charter Hospital, and Glenbeigh Hospital throughout the ORHS disciplinary process. (R2-52-126, 138). Thus, even during his temporary suspension at ORHS, Dr. Levine had access to several other hospitals with 1,623 licensed beds. Accordingly, Dr. Levine, and his patients, could access 37% of the licensed hospital beds in the Orlando Area even during the period of his temporary suspension. (R2-49-¶ 20 Exh. "I"). The inference of Dr. Levine's continued successful presence in the market and continued access to hospital facilities is that no patient was deprived of the opportunity to choose Dr. Levine as his or her physician for internal medicine services.

Although the review of the factual record in this case is arguably outside the scope of this Court's review on a petition for writ of certiorari, these Respondents felt that it was necessary to provide some of the relevant facts which were reviewed by the courts below in arriving at their decisions.

Dr. Levine also misstated several material facts in this matter. Specifically, Dr. Levine has attempted to portray CFMA as the alter ego of Healthchoice. These Respondents would suggest that the factual findings of the Eleventh Circuit Court of Appeals, set forth in its Opinion dated January 23, 1996, accurately depict the relationship of the parties and the relevant facts in this matter. Nevertheless, these Respondents feel compelled

to correct specific misstatements of fact made by Dr. Levine in his Petition:

1. Dr. Levine states that CFMA requires adherence by its members to the Master Payor Rate Schedule as a condition of membership in CFMA. However, the Master Payor Rate Schedule is developed by the non-physician board members of Healthchoice for the purpose of providing a means of compensation to be negotiated with third-party payors. CFMA has absolutely no input or direction in determining the amounts set forth in the Master Payor Rate Schedule and individual member physicians are free to opt out of any contract if they are unhappy with the fees. Moreover, the Master Payor Rate Schedule simply establishes the maximum amount that Healthchoice-contracted payors are required to pay physicians for services rendered to that payor's covered persons. Physicians are paid the lesser of their usual and customary charges or the amount calculated from the Master Payor Rate Schedule.

2. Dr. Levine also states that there are "68,000 CFMA patients". Dr. Levine is clearly aware that, at all times relevant to this action, there were approximately 68,000 Healthchoice enrollees. There are no "CFMA patients".

3. Dr. Levine asserts that CFMA promulgated the Rule of Necessity "by which physician participation in CFMA was closed to new applications unless an internally determined need existed for certain specialties" (*Levine Petition*, p. 3). The Rule of Necessity, as it currently exists and as it existed at all times relevant to this action, was promulgated by

Healthchoice as a means to provide the proper number of physicians in various subspecialties to cover the geographical territories served by the Healthchoice Preferred Provider Organization. The Rule of Necessity is administered by the staff of Healthchoice without input from CFMA members or other physician providers (R3-82-¶ 8).

4. Dr. Levine states that CFMA membership is closed to assure each CFMA doctor a sufficient number of patients to equal 15 to 20% of his respective practice and that CFMA members are required to do in-hospital rather than outpatient procedures. It has been well established that the Healthchoice provider panel is closed for the sole reason of providing provider physicians with the prospect of increased numbers of patients. In return, the physicians agree to accept set fees for their services and agree to submit themselves to rigorous quality control and utilization review by Healthchoice. The closed panel is required by many third-party payors.

5. Dr. Levine states that the Boards of Directors of CFMA and Healthchoice are "interlocking" (*Levine Petition*, p.6). The Board of Directors of Healthchoice is comprised of eight individuals, four of whom are physicians appointed by CFMA. The remaining four members are unrelated to CFMA. The Board of Directors of CFMA may or may not be limited to Healthchoice physicians and is not comprised at all of any members of the administration or staff of Healthchoice.

The statements described above are contrary to the facts that have been revealed in the this case. The U.S.

District Court and the Eleventh Circuit Court of Appeals, upon reviewing the actual factual record in this case, determined that Dr. Levine's antitrust claims were meritless. These Respondents respectfully suggest that this Court follow the factual findings set forth in the Eleventh Circuit opinion.[1]

II.

ARGUMENT AND CITATION OF AUTHORITY

A. Dr. Levine Has Not Shown Any Grounds For This Court To Grant His Petition For Writ Of Certiorari In This Matter.

Supreme Court Rule 10 provides that review on a Writ of Certiorari is a matter of judicial discretion. The Rule goes on to provide, in relevant part, that the factors to be considered by the Court in granting certiorari include the following:

> (a) the United States Court of Appeals has entered a decision in conflict with the decision of another United States Court of Appeals on the same important matter; . . . or has so far departed from the accepted and usual course of judicial proceedings, . . . as to call for an exercise of this Court's supervisory power;
>
> (c) . . . a United States Court of Appeals has decided an important question of federal law that has not been, but should be, settled by this

---

[1] Because this case went to the Eleventh Circuit on Appeal of Summary Judgment, it was required to construe the facts in the light most favorable to Dr. Levine. *Forbus v. Sears Roebuck & Company*, 30 F.3d 1402, (11th Cir. 1994), *cert. denied*, 115 S.Ct. 906 (1995).

> Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court (*Supreme Court Rule 10*).

The principal purpose for which the U.S. Supreme Court uses certiorari jurisdiction is to resolve conflicts among circuit courts of appeals concerning the meaning of a provision of federal law. *Braxton v. United States*, 500 U.S. 344, 111 S.Ct. 1854 (1991).

Dr. Levine has alleged that this Court should exercise its certiorari jurisdiction in this matter to clarify three conflicting standards for analyzing claims under Section 1 of the Sherman Act.[2] Dr. Levine also asserts that the Eleventh Circuit's failure to find a per se violation in this case violates prior Supreme Court precedent, thus justifying the grant of his Petition. However, as shown by its opinion and as more fully discussed below, the Eleventh Circuit reviewed each of the existing standards in reviewing Dr. Levine's Section 1 claims, and properly determined that his claims failed under the Rule of Reason. The Eleventh Circuit's decision was supported by prior decisions of this Court and by numerous other relevant Circuit Court decisions.

The Court's decision is also supported by public policy. This case involves a very successful physician who is aggrieved because he was denied admission to a particular managed care plan. Dr. Levine's only interest in becoming a Healthchoice provider was to increase his personal income. For example, he has never been interested in challenging the methods by which provider fees

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[2] 15 U.S.C. § 1

are set by Healthchoice, and, although he may argue to the contrary, has never been interested in changing the way that providers are admitted to the network. The Petitioner simply wants to become part of the network because he has heard it "pays well" (R2-54-65). There has been absolutely no evidence presented of any harm or the potential for future harm to competition in this matter. To the contrary, the uncontradicted evidence shows that no patient has been deprived of the use of the Petitioner's services and that Petitioner's medical practice thrived despite his exclusion from the Healthchoice provider panel *and* the temporary suspension of his medical staff privileges at ORHS. The facts of this case, including the competitive status of the relevant markets and the phenomenal success of the Petitioner's medical practice, make it a particularly poor vehicle to be used to review existing antitrust law. Therefore, this court should not accept certiorari jurisdiction in this matter and Dr. Levine's Petition should be denied.

B. There Is No Conflict Among This Court's Decisions Reviewing Alleged Sherman Act Violations Which Justifies The Exercise Of This Court's Certiorari Jurisdiction In This Matter.

Dr. Levine alleges in his Petition that this Court has allowed three conflicting legal standards for boycotts to "uneasily co-exist" (*Levine Petition*, p.11). Although the precise application of the Court's standards of review of antitrust cases is often not easily applied, the standards have developed over time in response to complicated fact patterns which demand sophisticated analysis. However, the facts of this case do *not* demand such analysis and do

not lend themselves to a meaningful review of the three legal standards.

This Court has historically provided that alleged combinations in violation of the Sherman Act should be reviewed as either per se violations or under the Rule of Reason. Per se violations have been found in situations where the defendants' actions are so plainly harmful to competition and so obviously lacking in any redeeming pro-competitive values that any alleged restraint is presumptively unreasonable. *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 8 (1979). The types of cases deemed per se violations are very limited. Such cases have generally been limited to those in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor. *F.T.C v. Indiana Federation of Dentists*, 476 U.S. 447, 458 (1986). In the vast majority of cases, the courts apply the Rule of Reason. In order to establish an antitrust violation under the Rule of Reason, the plaintiff must establish that the defendants have market power in the relevant product and geographic markets; and that the challenged combination or agreement constitutes an unreasonable restraint on competition. *Standard Oil Co. v. United States*, 221 U.S. 1 (1911).

A third standard of analysis was created by this Court in 1986 in its decision in the case of *F.T.C. v. Indiana Federation of Dentists, supra.* In *Indiana Federation of Dentists,* this Court, while specifically declining to classify the defendant's actions as a per se violation, held that the need to establish market power could be obviated where there was proof of "actual detrimental effects" on competition. *Id.* at 460-461. The Court held that the withholding

of dental x-rays from insurance companies by a majority of dentists in particular areas, thus eliminating price competition among the dentists, resulted in "actual, sustained adverse effects on competition . . . sufficient to support a finding that the challenged restraint was unreasonable even in the absence of elaborate market analysis". *Id.* at 461. It is within the framework of these three standards that modern antitrust cases are analyzed by the courts.

C. The Eleventh Circuit Court of Appeals Properly Decided That Dr. Levine's Antitrust Claims Were Meritless Under The Rule of Reason.

Under the Rule of Reason, the court must evaluate the alleged activity by analyzing the facts peculiar to the business, the history of the alleged restraint, and the reason it was imposed, so that it can evaluate the competitive significance of the activity complained of. *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978). The activity only violates Section 1 if it is adjudged an unreasonable restraint on competition. *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985). In *Northwest Stationers*, the plaintiff was expelled from membership in a lucrative cooperative buying agency after a relatively minor breach of the agency's bylaws. Plaintiff argued that its expulsion, without notice or an opportunity for a hearing, constituted a group boycott that should be deemed a per se violation of Section 1. The Supreme Court disagreed, stating that "Rule of Reason analysis guides the inquiry unless the challenged action falls into the category of agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue

are conclusively presumed to be unreasonable . . . " *Id.* at 289; quoting, *Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1958). Such cases are deemed per se unlawful. In *Northwest Stationers*, the court found that wholesale purchasing cooperatives were not an activity likely to have a predominantly anticompetitive effect, and applied the Rule of Reason, not per se, analysis. *Id.* at 295-298. Per se treatment of certain antitrust activity has been justified by this Court to avoid the burdensome inquiry into actual market conditions in situations where the likelihood of harm to competition arising from the activity is so great that the costs of such inquiry cannot be justified. *Jefferson Parish Hospital District 2 v. Hyde*, 466 U.S. 2 (1984).

Cases in which the Supreme Court has applied the per se analysis have generally involved joint efforts by a firm or firms to cut off access to a "supply, facility or market necessary for the boycotted firm to compete . . . ". *Northwest Stationers, supra* at 294. Therefore, in order to invoke the per se rule, the plaintiff must present a threshold case that the challenged activity fits into a category likely to have predominantly anticompetitive effects. *Id.* at 298. The types of cases to which per se analysis should be applied should not be expanded indiscriminately. *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. at 458.

(i) Group Boycott Claims Against Healthchoice and CFMA.

Following this Court's direction from the cases cited above, the Eleventh Circuit Court of Appeals properly applied the Rule of Reason to the Petitioner's antitrust claims against Healthchoice and CFMA. As shown by the

uncontroverted facts set forth above, the managed care market in the Orlando Area is very competitive. Healthchoice, with only 6% of the relevant market, has no ability to adversely effect competition. Each payor which contracts with Healthchoice is free to terminate its contract upon relatively short notice and negotiate agreements with other managed care plans. No Healthchoice physician is precluded from joining the provider panels of other managed care networks and, in fact, most physicians are members of several networks. As a result, it is virtually impossible for Healthchoice to restrict competition among other managed care plans. Finally, no patient who is not a Healthchoice member is precluded from using a Healthchoice physician. Even assuming arguendo that Healthchoice had conspired with CFMA or its member physicians to exclude Dr. Levine from the network, the Eleventh Circuit found that such action had no effect on competition in the market for internal medicine physician services. *Levine v. Central Florida Medical Affiliates, Inc., et al.*, 72 F.3d 1538, 1553 (11th Cir. 1996).

On the other hand, there are many pro-competitive reasons why Healthchoice would seek to restrict membership in its preferred provider network. By limiting the number of panel physicians, Healthchoice can assure that its providers get greater access to more patients. In return, the physicians are willing to accept lower fees for their services and submit themselves to quality assurance and utilization management review. By limiting the number of physician providers, Healthchoice is able to provide a quality product at a lower cost. This allows Healthchoice to compete more effectively with the 38

other PPOs, 11 other HMOs, and numerous TCIC companies in the Orlando Area. Significantly, Healthchoice submitted to the District Court in support of summary judgment an Affidavit by the health benefits manager of Healthchoice's largest managed care customer (Orange County Public Schools) in which this customer confirmed that it desired Healthchoice to operate a closed panel of physicians (R3-76-¶¶ 6, 7).

Cases relating to the exclusion of a particular provider from a managed care plan have been decided by other courts under the Rule of Reason. In *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Association, Inc.*, 996 F.2d 537 (2d Cir. 1992), a private radiology group of doctors was denied membership in an independent association of private physicians who were providing medical care through an HMO. The stated basis for the denial was that the radiology group was located outside the plan's designated service area. *Id.* at 540. As a result, the radiologists filed Sherman Act Section 1 and 2 claims against the independent physicians association and the HMO. The Second Circuit Court of Appeals affirmed the District Court's grant of summary judgment in favor of the defendants on the grounds that the plaintiff had not established an unreasonable restraint of trade under the Rule of Reason. The Court in *Capital Imaging* acknowledged the "Supreme Court's caution about extension of the per se doctrine into new areas, see *Indiana Fed'n of Dentists*, 476 U.S. at 458-59, [as well as] the recognized procompetitive virtues of . . . HMOs." *Id.* at 545. It also found that the defendants' actions had no actual detrimental effects because there was no evidence of an increase in prices or a deterioration of the quality of radiological

services to the plan's enrollees. *Id.* at 546. As a result, the court applied the Rule of Reason and found that the defendants were unable to injure competition because of their small market share. The same analysis holds true in this case.

Petitioner has cited no factually similar cases which support his claim that this case should be analyzed as either a per se violation of the Sherman Act or pursuant to the hybrid analysis set forth in *F.T.C. v. Indiana Federation of Dentists, supra*. Rather, Dr. Levine cites cases outside of the managed health care arena in an effort to classify the Healthchoice PPO as a per se illegal group boycott. However, cases such as *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), and *F.T.C. v. Superior Court Trial Lawyers Association*, 493 U.S. 411 (1990), upon which Petitioner heavily relies, are inapplicable to the facts in this case.

In *Klor's*, a large chain of retail department stores conspired with various manufacturers and distributors to prevent sales of electronics to the plaintiff. The complaint alleged that the combination effectively prevented Klor's from buying appliances in a competitive market and drove it out of business as a dealer in the defendant's products. *Klor's*, 359 U.S. at 213. The Court, in its opinion, clearly distinguished the facts in *Klor's* from the facts in this case when it stated that "[t]his is not a case of a single trader refusing to deal with another . . . " *Id.* at 212. Instead of a "wide combination" conspiring against a competitor, this case involves a single preferred provider organization which, through its administrative procedures, denied membership to a single physician. There

was no collaborative action and there was no harm to the physician's ability to compete in the relevant market.

In *Superior Court Trial Lawyers,* the boycott by a majority of lawyers providing indigent criminal defense services in the Washington, D.C. area had the effect of crippling an already over-burdened court system. *F.T.C. v. Superior Court Trial Lawyers Association, supra* at 417, 418. Again, there was an agreement among competitors which resulted in a substantial restraint on competition in the relevant market. The undisputed facts in this case clearly establish that Healthchoice does not compete in any market with Petitioner and that its actions in limiting its provider panel had no effect on competition.

None of the defendants in the above-cited cases offered any pro-competitive reasons for their actions. Conversely, Healthchoice presented uncontroverted evidence that its closed provider panel is demanded by its customers as a means of containing health care costs. Moreover, the Rule of Necessity, by which new physicians are admitted to the provider panel, is administered by non-physician staff members of Healthchoice without the input from its member physicians or the physician members of CFMA. Healthchoice provides a product – a package of medical services – that is marketed to third party payors in competition with other PPOs, HMOs and TCIC companies. It does not compete with the Petitioner. The complete lack of evidence of any anti-competitive effect and the pro-competitive reasons for the Rule of Necessity distinguish this case from those cited above. As a result, Dr. Levine's reliance on the "group boycott" cases is misplaced.

As recognized by the Department of Justice, the managed care market is relatively new to the healthcare industry. In its enforcement policies relating to multi-provider networks, the Department of Justice has noted that "where a geographic market can support several multi-provider networks, there are not likely to be significant competitive problems associated with the exclusion of particular providers by particular networks." *Levine*, 72 F.3d at 1550; citing DOJ Enforcement Policy, *available in* 1994 WL 642477 at *42 (F.T.C.). As previously stated, there were approximately 38 preferred provider organizations and 11 health maintenance organizations in the Orlando Area. These organizations had a combined coverage of approximately 69% of the population. The remainder of the population is covered by numerous traditional comprehensive insurance coverage companies in the area or have no coverage at all. Healthchoice had approximately sixty eight thousand enrollees or approximately a 6% share of the Orlando health care market. Accordingly, the Eleventh Circuit properly found as a matter of law that there was no significant anticompetitive effect resulting from the exclusion of Dr. Levine from this particular network.

(ii) Price-Fixing Claim Against Healthchoice and CFMA.

Dr. Levine has raised a new argument in his Petition. Specifically, he now asserts that the establishment of the Master Payor Rate Schedule by Healthchoice is a type of price-fixing which should be deemed per se unlawful. In reviewing the Complaint, it is interesting to note that the Petitioner did not raise any allegations of price fixing.

Specifically, Count I of his Complaint is simply titled "Conspiracy to Unreasonably Reduce the Availability of and Competition in Services to Consumers of Medical Services" (R1-1-5). In his portion of the Pre-trial Statement prepared by the parties on the eve of trial, Petitioner defined the concise issues to be tried relating to Count I of his Complaint as:

> "Did the Defendant's contract, combine or conspire with one another and/or among the doctor members at CFMA to exclude Plaintiff from being a provider under CFMA and/or Healthchoice?"; and
>
> "Did the Defendant create a health care plan (PPO) that locked in consumers and excluded physicians like Plaintiff?" (R3-132-23).

Price-fixing was not even an issue to be litigated at the trial. In fact, throughout this litigation, the Petitioner's complaint has been that he was excluded as a member of the Healthchoice PPO. He wanted to become a member of the Healthchoice PPO because he heard it paid well and he thought it would improve his practice (R2-52-438, 439); (R2-54-65). He wanted to become a part of the plan not challenge the method by which fees are set. As a result, the Eleventh Circuit properly found that there was "no genuine issue of material fact regarding the existence of an agreement to fix prices . . . ". *Levine*, 72 F.3d at 1549.

Dr. Levine compares this case with this Court's decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). In *Maricopa*, a group of doctors representing approximately 70% of the practitioners in the area formed an association for the purpose of establishing a schedule of maximum fees that participating doctors

would accept as payment in full for services performed for patients insured under approved plans. *Id.* at 339. The *physicians themselves* agreed by majority vote on the maximum fee that they would claim as payment in full for their services. *Id.* at 335-336. The Court acknowledged that fee schedules may be desirable in certain circumstances, but appeared troubled by the fact that the fees were set by the physicians themselves. *Id.* at 352. As a result, a closely divided Court found that the arrangement in question was a form of illegal price-fixing. *Id.* at 357.

In the present case, it is the non-physician members of the Board of Directors of Healthchoice that establish the rates and conversion factors which are used to make up the Master Payor Rate Schedule. The physician members of the Board of Directors of Healthchoice are required to remove themselves from any discussions regarding the establishment of rates for physician services. The rates are then negotiated by Healthchoice individually with prospective payors and the agreed upon rate schedule is presented, in toto, to the provider panel. Any doctor is free to opt out of any contract under which he is unhappy with the amount of the fee to be received. The provider is also free to accept an amount less than the proscribed maximum fee or to waive any copayment which may be due from an out-of-network provider. Any physician is also free to join other managed care networks if the fees are more favorable or for any other reason. Therefore, this case can be easily distinguished from *Maricopa County* as the maximum fees for individual physician services are determined by an independent entity seeking to market its package of physician services to

third-party payors such as large businesses and local governments.

The Eleventh Circuit acknowledged that the Petitioner did not argue in the court below that the Respondents had illegally fixed prices. However, the Eleventh Circuit also noted that portions of Petitioner's brief assumed the existence of such an agreement and addressed, in dictum, Petitioner's alleged price-fixing claims. The court found that the Healthchoice PPO involved "an agent or third party conveying to purchasers information obtained individually from providers in the network about prices the network participants are willing to accept, and conveying to providers any contract offers made by purchasers." *Levine*, at 1549. As a result, the method by which Healthchoice negotiates the fees to be paid to its providers was not prohibited by the Sherman Act.

Although some managed care plans have come under scrutiny lately, those cases have involved *jointly owned* physician-hospital organizations with extremely large market shares which allegedly restrained competition among the physicians and impeded the entry of other managed care plans into the relevant markets. In *United States v. Health Choice of Northwest Missouri, Inc.*, No. 95-6171-CV-5J-6 (W.D.Mo.), reprinted in, 60 Fed.Reg. 51,808 (Oct. 4, 1995) and *United States v. HealthCare Partners, Inc.*, No. 395-CV-01946-RNC (D.Conn.), reprinted in, 60 Fed.Reg. 52,014 (Oct. 4, 1995), the Department of Justice alleged physician participation in the relevant markets of 85% and 98%, respectively. In addition, the relevant hospitals in both cases were the only acute care

hospitals in their respective markets. There was also evidence that the physicians refused to deal with any managed care plans except through their organization and that the organizations were restricting access to the physicians. Therefore, the Department of Justice felt that the structure of the organizations in question had the potential to restrict price competition among the physicians and limit the development of managed care plans.

In the present case, Healthchoice is not owned by the physician providers. The PPO has a very small market share in a highly competitive market. In addition, all of the agreements with its providers allow the physicians to participate in other competing managed care plans. Even the President of Healthchoice participates in several other competing managed care plans (R3-83-¶ 4). Healthchoice is unable to restrict access to its physician providers or limit price competition because any effort to unilaterally raise prices above market levels would result in payors (and physicians) switching to one of the other managed care plans in the area. This case is clearly distinguishable from those that have been challenged by the government. More importantly, an action brought by a single physician challenging his exclusion from a managed care network is not an appropriate vehicle for review of managed health care by this Court.

(iii) Group Boycott Claims Against ORHS.

Dr. Levine also argues that the temporary suspension of his medical staff privileges by ORHS should have been deemed per se illegal. He ignores the fact that the peer review process is a requirement for licensing under state

law. He also ignores the fact that he at all times maintained (and utilized) active staff privileges at other hospital facilities in the Orlando area, including the largest hospital network in the area. Most importantly, Dr. Levine is asking this Court to ignore the benefits to patient care which are attributable to the physician peer review process. The benefits of having a physician's work reviewed by other doctors having knowledge in the medical field is beyond dispute. Physician peer review is not an activity which can be said to have such obvious anti-competitive effects as to justify classification as a per se violation of the Sherman Act. Dr. Levine's argument is merely an attempt to re-litigate his disciplinary proceeding in a federal treble damages forum.[3] Such a result is not within the spirit and intent of the federal antitrust laws.

Numerous decisions have addressed the issues of medical staff disciplinary actions under the Rule of Reason. See, e.g., *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), *cert. denied*, 112 S.Ct. 1972 (1992); *Bolt v. Halifax Medical Center*, 891 F.2d 810 (11th Cir. 1990), *cert. denied*, 495 U.S. 924 (1990); and *Lie v. St. Joseph Hospital of Mt. Clemmons, Michigan*, 964 F.2d 567 (6th Cir. 1992). In fact, these respondents are unaware of a single case in which a medical staff disciplinary action has been deemed a per se violation of the Sherman Act. As acknowledged by counsel for Dr. Levine at oral argument at the Eleventh Circuit, the proper standard for antitrust

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[3] Dr. Levine also filed a companion case asserting state law claims against ORHS which remains pending. (Orange County, Florida Circuit Court Case No. CI93-1478).

claims arising from medical staff disciplinary actions is the Rule of Reason. *Levine,* 72 F.3d at 1553. A contrary holding would federalize the state-mandated peer review process and provide a treble damages forum for any disgruntled physician who was aggrieved by the process.

In *Oksanen v. Page Memorial Hospital, supra,* the plaintiff's medical staff privileges were revoked by the medical staff at the defendant hospital based on allegations of numerous incidents of disruptive behavior at the hospital. In response, Dr. Oksanen sued the hospital and members of the medical staff alleging Sherman Act Section 1 and 2 violations and other state law violations. The court found that Dr. Oksanen's efforts to show an unreasonable restraint on trade were not satisfied by showing only that he had suffered an economic injury. *Oksanen, supra,* at 708. As stated by the Court:

> If the law were otherwise, many a physicians' workplace grievance with a hospital would be elevated to the status of an antitrust action. To keep the antitrust laws from becoming so trivialized, the reasonableness of a restraint is evaluated based on its impact on competition as a whole within the relevant market. *Id.* at 708; *Atlantic Richfield Co. v. USA Petroleum Co.,* 495 U.S. 328 (1990).

Therefore, while the court recognized that Dr. Oksanen's individual practice may have been hurt by the hospital's actions, there was no evidence that competition had been harmed in the relevant market. *Id.* at 709. As a result, Dr. Oksanen's Section 1 claim failed.

The modified Rule of Reason analysis propounded by the court in *Indiana Federation of Dentists* is also inapplicable to a peer review case. *Lie v. St. Joseph Hospital of Mount Clemmons, Michigan, supra.* In *Lie,* the plaintiff's surgical privileges were suspended after an extended review indicated that the patient care he had rendered was unacceptable. As a result, Dr. Lie sued the hospital and certain individual physicians for antitrust violations (specifically, Sherman Act Section 1). Although he attempted to define the relevant market, Dr. Lie argued that he did not have to establish that the defendant hospital had market power under the authority of *F.T.C. v. Indiana Federation of Dentists,* 476 U.S. 447 (1986) (the presence of a "naked restriction on price or output" does not require an inquiry into market power. *Id.* at 460). However, the Sixth Circuit Court of Appeals rejected this argument. Instead, the Court recognized that the peer review process has a public purpose of policing the competence of physicians and can enhance competition. *Lie,* at 570. Therefore, the plaintiff was required to allege and prove market power and an unreasonable restraint on competition. The only evidence produced by Dr. Lie was a reduction in his own income and an affidavit from an expert that the peer review process could chill competition among physicians. The court found that evidence insufficient to establish an unreasonable restraint on trade, especially in view of the defendant's evidence of an increase in the number of surgeons practicing in the area. *Id.* at 570.

Dr. Levine continues to rely on Justice Scalia's dissent in *Summit Health, Ltd. v. Pinhas,* 111 S.Ct. 1842 (1991). This Court reviewed the *Summit Health* decision solely to determine whether the complaint in that case satisfied the

interstate commerce requirement of antitrust jurisdiction. *Id.*, at 1844. Justice Scalia, while dissenting from the majority's holding that the jurisdictional requirement was satisfied, also expressed his displeasure at the prospect of "federalizing" physician disciplinary actions. Specifically, Justice Scalia wrote that it was a mistake to treat claims over the denial of hospital privileges as federal antitrust claims because the federal courts should not be trivialized by the handling of routine business disputes. *Id.*, at 1854. These Respondents agree with this analysis.

The decision of the Eleventh Circuit to analyze the Petitioner's antitrust claims against ORHS under the Rule of Reason was consistent with decisions from other Circuits which have faced similar situations. All have required that the Plaintiff satisfy the Rule of Reason to pursue an antitrust claim relating to a physician disciplinary procedure because the pro-competitive and other societal benefits of physician peer review far outweigh any alleged anticompetitive effects. The Petitioner has never made any effort to attempt to identify or define the relevant product and geographic markets relating to his Section 1 claims against ORHS. Instead, he relied on a per se analysis or the *Indiana Federation of Dentists* hybrid analysis. The only evidence relating to market definition in this case was provided by the Respondents. The Eleventh Circuit gave the Petitioner every benefit of the doubt while analyzing his antitrust claims against ORHS under the Rule of Reason. The overwhelming result of such analysis was that the Petitioner had failed to prove that the disciplinary action in this matter had any effect on competition in the relevant markets. *Levine*, 72 F.3d at 1554. The Eleventh Circuit properly applied the Rule of

Reason in affirming the summary judgment granted against Dr. Levine on his antitrust claims against ORHS in this matter and certiorari should not be granted to review its decision.

(iv) "GVR"

These Respondents join in that portion of the Response Brief filed by CFMA relating to the reasons why "GVR" is inappropriate in this matter.

III.

CONCLUSION

The most cogent arguments for the denial of Dr. Levine's Petition can be found in the Eleventh Circuit's Opinion. The judges obviously reviewed the matter thoroughly and provided an insightful analysis of the relevant antitrust precedents. There is no reason for this Court to review the Eleventh Circuit's decision in this case. The decision below was substantively correct and was not a product of any "confusion" in the law.

In addition, given the increasing importance of managed care and the requisite development of provider networks involved in managed care, it would be a serious mistake to open the doors of the federal courts as a forum for review of network decisions made by the many managed care plans operating and being developed across the country. The formation of such networks, which is being demanded by market forces, necessarily means that some providers will be in a network and some will be

excluded. If Dr. Levine's position is accepted, every provider who is excluded from a particular network would be a potential federal court antitrust plaintiff. The appealing lure of treble damages would only serve to increase the potential that such claims would be filed.

Where there is *no* evidence of any detrimental effect on competition, as the courts below in this case have noted, it would be an extreme departure from prior law to allow a federal antitrust action to proceed. The acceptance by the Supreme Court of the argument that provider exclusions from managed care plans are per se antitrust violations would completely federalize the law in this area and would insert the federal courts into the market relationships between willing buyers and sellers in a highly detrimental fashion. Therefore, for the reasons set forth above, Orlando Regional Healthcare System, Inc., Sand Lake Hospital, and Healthchoice, Inc. hereby respectfully request that Dr. Levine's Petition for Writ of Certiorari be denied.

Respectfully submitted,

DAVID L. EVANS, Esquire
Florida Bar No. 260312
THOMAS R. HARBERT, Esquire
Florida Bar No. 817759
MATEER & HARBERT, P.A.
225 East Robinson Street, Suite 600
Post Office Box 2854
Orlando, Florida 32802
Telephone: 407/425-9044
Fax: 407/423-2016
Attorneys for Orlando Regional Healthcare System, Inc., Sand Lake Hospital and Healthchoice, Inc.

Supreme Court, U.S.
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No. 95-2000

In The

Supreme Court of the United States

October Term, 1995

SCOTT D. LEVINE, M.D.,

Petitioner,

vs.

CENTRAL FLORIDA MEDICAL AFFILIATES, INC.; HEALTHCHOICE, INC.; SAND LAKE HOSPITAL; ORLANDO REGIONAL HEALTHCARE SYSTEM, INC. f/k/a ORLANDO REGIONAL MEDICAL CENTER,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

JOHN C. BUTTERS
Attorney for Petitioner
P.O. Box 7129
Atlanta, GA 30357-0129
(404) 872-5693
(404) 876-3331 (Fax)
(Counsel of Record)

JAMES F. PONSOLDT
Of Counsel
Univ. of Georgia
School of Law
Athens, GA 30602
(706) 542-5209

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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REPLY ARGUMENT

I. THE RECURRING ISSUE PRESENTED BY THIS CASE IS WHETHER A MARKET SHARE SCREEN SHOULD BE USED IN HORIZONTAL BOYCOTT CASES WHERE THE BOYCOTT LIMITS PRICE AND SERVICE COMPETITION AND CONSUMER CHOICE

The lead argument in the brief of CFMA suggests that there is no confusion over when to apply the per se rule or the rule of reason to horizontal restraints, and there is no confusion regarding the nature of rule of reason analysis in horizontal boycott cases where the boycott prevents service and price competition.[1] According to CFMA those issues are controlled by this Court's opinion in *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 105 S.Ct. 2613 (1985). CFMA's argument fails to discuss two subsequent boycott decisions, *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 106 S.Ct. 2009 (1986), and *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 110 S.Ct. 768 (1990).

When these more recent opinions are read in conjunction with *Northwest Wholesale*, from a pragmatic,[2] substantive, perspective the issues have a single focus central to

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[1] CFMA also argues that Petitioner lacks standing. The CFMA brief is signed by new counsel who did not participate in or attend the oral argument before the Eleventh Circuit. This may explain why new counsel is apparently unaware that counsel for defendants abandoned the standing argument at oral argument before the Eleventh Circuit, and that the Eleventh Circuit abandoned standing as a basis for summary judgment.

[2] Debate over the prohibitive costs of antitrust enforcement under a rule of reason analysis continues today regarding the proposed Antitrust Health Care Advancement Act of 1996 (H.R.

Sherman Act litigation: When is use of a market share screen or proof of a relevant market required?

The Respondents' briefs admit there are three differing legal standards for the evaluation of the legality of group boycotts,[3] and horizontal restraints under Section 1 of the Sherman Act, generally, as described in the Petition for Certiorari.

CFMA clarifies that the boycotts in this case[4] are horizontal combinations of competitors who literally

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1925) (a bill which would require health care provider networks to be evaluated under the rule of reason). In analyzing the increased costs the Congressional Budget Office estimates that state governments would spend $5-15 million, and the federal government would spend $1-5 million more on enforcement. Presumably these substantial increases in cost would be due to having to prove market definition and market share, in contrast to a "quick look" rule of reason analysis under *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85, 104 S.Ct. 2948 (1984), or *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 106 S.Ct. 2009 (1986). See, CCH Trade Reg. Reports, No. 431, July 24, 1996.

[3] Respondents Healthchoice and ORHS acknowledge that "the precise application of the Court's standards of review of antitrust cases is often not easily applied . . . " [Brief of Healthchoice and ORHS p. 11].

[4] As noted in the Petition for Certiorari, Count I of the Complaint challenged a refusal to deal among competing doctor members of CFMA, through the "CFMA Rule Of Necessity" (limiting membership in CFMA), CFMA rules prohibiting CFMA doctors from referring to or consulting with nonmembers, and Healthchoice rules limiting patients from employing non CFMA doctors. Count III challenged a refusal to deal among ORHS doctors and hospitals who combined to suspend Petitioner's admitting privileges, emergency room privileges, and privileges to do medical procedures, thereby refusing to deal with him in any of those contexts.

refuse to deal with a competitor – historically the paradigm boycott situation.[5]

In particular, CFMA tries to distinguish the application of the *per se* rule in *F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 110 S.Ct. 768 (1990), stating that such case involved a situation where the victim of the boycott was a buyer whereas in the case at bar the victim was a competitor. CFMA also argues that in the case at bar the refusals to deal are accomplished directly by Respondents rather than through coercion of third parties.

These distinctions backfire, as they fly directly into the teeth of the primary characteristics of *per se* illegal boycotts – the literal direct concerted refusal to deal with a competitor. See, *Eastern States Retail Lumber Dealers' Assn. v. United States*, 234 U.S. 600, 34 S.Ct. 951 (1914) (victims of boycott were competing lumber dealers); *Fashion Originators' Guild Of America v. F.T.C.*, 312 U.S. 457, 61 S.Ct. 703 (1941) (victims of boycott were competing garment makers); *American Medical Assn. v. United States*, 130

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[5] At page 2 of their brief ORHS-Healthchoice contend, with no citation to the record, that Petitioner was suspended for concerns regarding quality of care of patients. The record totally refutes this unfounded comment. Beginning on page 19 of its brief ORHS-Healthchoice suggest Petitioner lost his staff priviliges as part of "peer review." This is incorrect. Petitioner was maliciously suspended despite a perfect quality assurance record based on 100% chart review. Moreover, ORHS did not even assert the Healthcare Quality Improvements Act of 1986, 42 U.S.C. § 11101 et seq., as a basis for summary judgment. Petitioner was suspended and defendants consequently refused to deal with him because according to them he was a "Jack Of All Trades," and "taking money out of our pockets."

F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943) (victims of boycott were competing doctors); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 79 S.Ct. 705 (1959) (victim of boycott was competing retail store); *U.S. v. General Motors Corp.*, 384 U.S. 127, 86 S.Ct. 1321 (1966) (victims of boycott were competing car retailers).

Finally, when it is clear from the record that the target of the boycott was providing and would have provided superior service for a reduced aggregate fee, as Petitioner's documented extraordinary success demonstrates,[6] and the boycott is to eliminate that competitive

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[6] The success of Petitioner was both financial and professional. According to patient testimonials, Petitioner provided far better patient care than the community norm. Excerpts from a few letters from patients or their families are as follows: "[Dr. Levine] visited my mother frequently and *always* answered pages within seconds when he was called by the nurses." "The evening of her dismissal he spent more than two hours writing a very thorough and complete discharge summary. He also had all x-rays and reports copied so they could travel with my parents back to Illinois . . . [My mother's doctors in Illinois] couldn't believe that such extraordinary/thorough care is available to 'tourists.' They assured my father that Dr. Levine's care most definitely prevented my mother from the devastating effects of a stroke." (R4-110, Tab 7 pg. 00208-09).

"Dr. Levine, I have never in my life met a Dr. that has been so caring and compassionate . . . I really appreciate you understanding my financial situation and hopefully in the near future I can pay you . . . " (R4-110, Tab 7, pg 00213).

"Dear Ms. Gilliam [Hospital Administrator]: I was recently a patient at your hospital and even though I've already filled out your questionnaire I felt I should let you know about the excellent care that Dr. Scott Levine gave me while I was there. He is an excellent doctor and I really appreciate his aggressive

threat to price stabilizing activities, any attempt at justification at least becomes a jury issue. In other words, Petitioner's meteoric success is direct evidence of the anticompetitive motive and effect of Respondents' conduct. Only in a command economy would such success be a purported justification for the elimination of a competitor.

II. PETITIONER IS NOT CHALLENGING ALL JOINT SELLING VENTURES OR ALL MANAGED CARE SYSTEMS

Respondents claim that they closed membership and then refused to deal with Petitioner and others to encourage competing doctor members to charge lower fees in exchange for reduced competition. There are three problems with that purported justification: (1) there is no evidence whatsoever that fees charged by CFMA members, which admittedly are uniform, are "discount." Respondents have failed to demonstrate that their fees are in fact lower than those charged, for example, to patients of capitated healthcare plans, or to medicare patients, or any other category of patient. The evidence introduced by Petitioner is that noncapitated fees are higher than normal, not discounts. See, New York Times Article "Health Plans Force Changes In the Way Doctors Are Paid," February 9, 1995, attached to REPLY BRIEF OF APPELLANT to the Eleventh Circuit; (2) there is no evidence whatsoever that CFMA members would not charge

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care. All three doctors were good, but Dr. Levine was the best. I owe my fast recovery to him. . . . " (R4-110, Tab 7, pg. 00225).

allegedly "reduced fees" without the CFMA Rule Of Necessity, and the evidence is that CFMA and Healthchoice for years had no such rule, grew rapidly, and were open to all providers; (3) and, there is no evidence that aggregate fees, not merely fee schedules, are reduced by CFMA's refusal to deal and in fact the prohibition of referrals to non-CFMA members prevents price competition and promotes heightened use of CFMA specialists at greater costs.

As in *U.S. v. Topco Associates, Inc.*, 405 U.S. 596, 92 S.Ct. 1126 (1972), the issue is not whether the existence of a PPO or joint selling arrangement can be justified, but rather whether the challenged constellation of anticompetitive practices has been justified; the answer in this case, as in *Topco* and in *Palmer v. BRG*, 498 U.S. 46, 111 S.Ct. 401 (1990) (which also involved a joint selling arrangement), clearly is "no."

III. RESPONDENTS' ARGUMENT THAT CFMA DID NOT PROMULGATE THE "RULE OF NECESSITY," IS REFUTED BY THE DOCUMENTARY RECORD

At page 7, paragraph 3 of its brief ORHS-Healthchoice asserts that Petitioner made a misstatement of fact when he said the Rule of Necessity was promulgated by CFMA. According to Healthchoice's brief, "[t]he Rule of Necessity . . . was promulgated by Healthchoice . . . [and] [t]he Rule of Necessity is administered by the staff of Healthchoice . . . " Respondents' own documents refute this statement by Healthchoice. Attached to the REPLY BRIEF OF APPELLANT before the Eleventh Circuit is a document produced by Respondents. It is entitled:

"CFMA RULE OF NECESSITY." It discusses that only in very limited circumstances of necessity will additional doctors "be credentialed for membership in CFMA's physician panel." It emphasizes that those doctors will have to agree to be bound by the "same contract fees . . . as other physicians on the CFMA physician panel.[7]" Healthchoice is not mentioned in this document.

IV. CFMA AND HEALTHCHOICE ARE INSTRUMENTALITIES OF EACH OTHER

CFMA and Healthchoice Boards of Directors overlap. At least four members of the Board of Directors of Healthchoice (R4-110-Tab 32 at 100077) are members of the Board of Directors of CFMA, which requires adherence by CFMA members to the fee schedule.[8] (Smith Dep. 7/21/93 pp. 11-13). Moreover, the executive staff and offices of Healthchoice are identical to those of CFMA. (Smith Dep. 8/94; Neder Dep. p. 14).

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[7] At page 5 of its Brief, CFMA points out that CFMA is not owned by the hospital, but rather "CFMA is owned by its physician members . . . " Even though CFMA was originated by the hospital parent, Petitioner appreciates this correction. As discussed herein, ownership and voting control of CFMA by the competing doctor members unquestionably makes that organization a horizontal combination under section 1 of the Sherman Act. See e.g. *Topco*, supra.

[8] Healthchoice's assertion that the Boards of Directors are not interlocking is wrong. In her deposition, Nancy Smith, an employee of ORHS and Executive Director of Healthchoice, (Smith Dep. 7/21/93 at p. 1), testified that at least four individuals were members of both the Healthchoice and the CFMA boards of directors – Neder, Galceran, Stephens and Kessell. (Smith Dep. 7/21/93 at pp. 12-13).

Dr. Neder was the president of CFMA and on the Board of Directors of both CFMA and of Healthchoice. (Neder dep. pp. 6-9). The identity of CFMA and Healthchoice is so lacking in separation that Dr. Neder thought CFMA was a PPO and that Healthchoice was not a PPO, but just did "sort of marketing." (Neder dep. p. 6). Dr. Neder also testified that Dr. Galceran was on the Board of Directors of both Healthchoice and CFMA. (Neder dep. pp. 6-9). Dr. Galceran was also the Chief of Staff at Sand Lake Hospital (R4-95-12-13), and was the person who intitiated Petitioner's unfounded suspension immediately after Petitioner made efforts to open CFMA to competing doctors. Dr. Galceran also added a new internist in his office to the CFMA membership immediately after suspending Petitioner. (R4-110-Tab 1, 4, 6, 10-12). The stock in CFMA is owned by the doctor members of CFMA. (Neder dep. p. 12).

Accordingly, Respondents' attempt to argue that Healthchoice is similar to an independent insurance company lacks credibility.

V. PETITIONER PLAINLY RAISED PRICE-FIXING IN BOTH LOWER COURTS, AND THE ELEVENTH CIRCUIT'S REJECTION OF THAT CLAIM SHOULD BE SUMMARILY REVERSED OR VACATED

The Respondents do not contest that the Eleventh Circuit ignored at least 60 years of antitrust jurisprudence when it held that the fixing of only one factor of a two factor price "is a kind of 'price fixing,' but it is a kind that the antitrust laws do not prohibit." 72 F.3d at 1548.

Rather, page 20 of the ORHS-Healthchoice brief suggests Petitioner did not assert price fixing in his complaint.[9] ORHS-Healthchoice have not read the complaint closely. Count I is captioned "CONSPIRACY TO UNREASONABLY REDUCE THE AVAILABILITY OF AND COMPETITION IN SERVICES TO CONSUMERS OF MEDICAL SERVICES." Paragraph 27 further asserts: "The policies and practices of CFMA in conspiracy with its members, with Healthchoice, and with others have . . . reduced price competition."

As in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 100 S.Ct. 1925 (1980), and *Palmer v. BRG*, 498 U.S. 46, 111 S.Ct. 401 (1990), and as requested by the Solicitor General in each of those cases, this Court should summarily reverse or vacate the decision below.

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[9] Moreover, CFMA contends at page 18 of its brief that CFMA and its members had no involvement in the price fixing combination. That is refuted by the record as discussed above. Respondents do not deny that CFMA requires members to adhere to the Master Payor Rate Schedule, resulting in uniform fees by CFMA members. Moreover, as cited above the actual staff who establish the fees, as well as members of the boards of directors, are agents of both CFMA and Healthchoice.

CONCLUSION

The Petition For Certiorari to review the judgment of the United States Court Of Appeal for the Eleventh Circuit should be granted.

Respectfully submitted,

JAMES F. PONSOLDT
Of Counsel
Univ. of Georgia
School of Law
Athens, GA 30602
(706) 542-5209

JOHN C. BUTTERS
Attorney for Petitioner
P.O. Box 7129
Atlanta, GA 30357-0129
(404) 872-5693
(404) 876-3331 (Fax)
(Counsel of Record)